

**TRANSMISSION OF AIDS PREVENTION MESSAGES IN BLACK FAMILIES
WITH ADOLESCENT CHILDREN**

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ABSTRACT

TRANSMISSION OF AIDS PREVENTION IN BLACK FAMILIES WITH ADOLESCENT CHILDREN

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The study assessed the level of AIDS knowledge in Black families with adolescent children, and identified the cognitive-behavioral skills associated with such knowledge. The assessment focused upon general AIDS knowledge, and knowledge of transmission and prevention.

Subjects are 129 male and female household heads, currently residing in an inner-city public housing project. The housing project is located in Harlem, an urban community within New York City. Subjects were recruited through the use of flyers and periodic announcements within the housing complex.

An AIDS Knowledge and Attitude Schedule was used to measure the level of AIDS knowledge in three areas, general knowledge, knowledge of AIDS transmission and knowledge of prevention. The Frequency of Self-Reinforcement Questionnaire was used to measure the extent to which respondents used self-reinforcement. The Problem-Solving Inventory was used to measure how individuals perceived

themselves to have reacted to problems faced on a daily basis. The Simple Rathus Assertiveness Schedule was used to measure the assertiveness.

The respondents manifested misconceptions about how AIDS is transmitted and prevented. The respondents were less knowledgeable about AIDS when compared with a national sample of Black Americans. General AIDS knowledge and knowledge of transmission are correlated with assertiveness. Knowledge of AIDS transmission is correlated with perceived problem-solving ability. Respondent's perceived comfort in discussing AIDS and sex with their children is correlated with perceived problem-solving ability.

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INTRODUCTION

The goals of this research were to assess the extent to which a sample of black parents in public housing transmit AIDS- related prevention messages to their adolescent children, and to identify skills that potentially accompany such transactions. An understanding of these dynamics could inform the development of preventive interventions targeted at African-American families in high risk neighborhoods.

AIDS, originally perceived as a disease of gay men, has made significant inroads into other population groups. Increasingly, blacks and Hispanics, including women and children are becoming infected with the human immunodeficiency virus (HIV). Adolescents have thus far been among the least affected, but many are likely to become infected as the virus moves through secondary communities and new risk groups. BY virtue of their sexual behavior and association with high-risk persons, black adolescents merit attention. Needed are culturally specific intervention strategies that reach adolescents through a variety of channels. One avenue, yet untried, is the black family.

STUDY AIMS

1. Measure the knowledge and attitudinal risks related to AIDS, among black parents in public housing and compare this data with a national data set of black Americans.

2. Measure the extent to which black parents possess specific cognitive-behavioral skills needed for effective interaction with their adolescent children.
3. Determine whether there is a relationship between AIDS knowledge and specified demographic variables.
4. Determine whether there is a relationship between AIDS knowledge and specified cognitive-behavioral skills.
5. Identify potential knowledge and skill components for family-based AIDS prevention programs.

SIGNIFICANCE OF THIS STUDY

Acquired immunodeficiency syndrome (AIDS), is a viral infection transmitted primarily through sexual activity and the sharing of intravenous drug injection equipment. The severity of AIDS was not known when the initial cases were identified in 1981 (Becker & Joseph, 1988). The ensuing years have informed us of the nature of this disease. More than half of those stricken with the disease have died (Altman, 1989; Heyward & Curran, 1988), and available data indicate that all persons infected with the human immunodeficiency virus (HIV) will die of AIDS.

The high mortality rate for AIDS is manifested in the minority community. Black men, women, and children are disproportionately represented among active AIDS cases (Rogers & Williams, 1987; Williams, 1989; Langone, 1989).

Unlike syphilis and most other sexually transmitted diseases, there is no cure for AIDS. Thus we are dependent upon preventive approaches for the eradication and control of this disease.

The findings from this study may have implications for the design of appropriate interventions for use with high risk inner city residents of public housing projects. Social service agencies could direct their human and monetary capital toward interventive activity at the family level with family empowerment as an emphasis. Family level intervention might enhance other interventive models, including peer-oriented and school-based approaches.

BACKGROUND AND CHRONOLOGY OF THE PROBLEM

AIDS AND BLACK AMERICANS

Black Americans represent about 12 percent of the United States population, but constitute 26% of persons diagnosed as having AIDS (Center for Disease Control, 1988). Among women with AIDS, 54% are black. Of all children with AIDS in the United States, 55% are black. Twenty-four percent of men with AIDS are Black. Among new applicants for the military, the rate of infection for blacks is 6.9 times higher than that of whites. Of AIDS cases in New York city, 54% are among either black or Hispanic persons (New

York city Department of Health, 1987). Nationally, minorities account for 40% of all AIDS cases (Langone, 1989).

BLACKS AND RISK FACTORS

AIDS is acquired through the human immunodeficiency virus (HIV), transmitted by homosexual and heterosexual contacts, intravenous drug use, contact with contaminated blood, and perinatal exchange from infected mothers to infants (Becker & Joseph, 1988). Because of existing behavioral patterns, blacks are considered at high risk of contracting AIDS.

Among blacks, homosexual and bisexual men account for 43.6% of all cases. Heterosexual intravenous drug users constitute 35.4% of AIDS cases among black Americans (Mays & Cochran, 1987). Blacks infected with HIV are less educated and poorer than their white counterparts. Blacks are disproportionately represented within the prison population, where homosexuality is practiced as a life style. Of male prison entrants in New York State during the period December, 1987 through January, 1988, 39.3% of those who tested positive for HIV antibody were minority group members (New York State Department of Health, 1989).

Among persons with AIDS in New York State, blacks and Hispanics makeup 59% of cases associated with IV drug use. Approximately 90% of pediatric cases are either black or

Hispanic as are 80% of the females with AIDS (New York State Department of Health, 1989).

BLACK YOUTHS AND AIDS

Risk factors for youths are less clear when compared with those of adults. Approximately 21% of AIDS patients were diagnosed during the age range of 20 to 29 (CDC, 1988). The long incubation period suggests that for a portion of these persons, AIDS was contracted during their adolescent years.

Recent data indicate that minority group members account for more than half of adolescents with AIDS. A significant proportion of these cases are attributable to heterosexual exchanges. The infected adolescent is most likely to be male (Report of the Second Public Health Service AIDS Prevention and Control Conference, 1988).

Crack use has been associated with engaging in high risk behaviors. Available reports indicate that While under the influence, some young people engage in sex with high risk individuals without the use of condoms or other protective measures (Kerr, 1988). Crack related activities are increasing among blacks (Bowser, 1988). A recent interview with a group of Black parents indicated a high level of awareness about the relationship between crack use and AIDS. Some parents noted that sex is often exchanged

for drugs among teens in their neighborhood (Focus Groups, 1989).

A recent survey of 10th graders in Philadelphia Public schools, a predominantly black system, found that:

- 1.) Of those surveyed, 92.5% were aware that AIDS is transmitted through sexual activity; 67% said that they never, rarely or only sometimes used condoms.
- 2.) About 29% indicated that they had their first sexual encounter by age 12.
- 3.) More than 56% never talked to their sex partners about AIDS before intercourse (Mezzacappa, 1989).

The survey also found that 73% of non-white students were sexually active compared to 50% of white students. More boys than girls were sexually active. Four percent of the respondents admitted to past and present intravenous drug use.

Respondents often had faulty understanding of how AIDS is transmitted. Forty-three percent believed that people can contract AIDS from having blood tests; 10.5% shaking hands; 55% from using public toilets; 68% from being bitten by a mosquitos; 32% from attending school with a person with AIDS; 69% from kissing on the mouth, and 56% from giving blood (Mezzacappa, 1989).

Such beliefs and behavioral practices render the students at risk of contracting AIDS. The misperceptions

about how AIDS is transmitted will lead to inappropriate transactions with others.

APPROACHES TO ADOLESCENTS AND THEIR PROBLEMS

Macro level intervention is currently emphasized. Macro level interventions are those that attempt to effect behavioral changes in large groups, institutions, and communities, but do not involve one-to-one or small group contacts. Macro level interventions include school-based approaches, the use of mass media or other community wide efforts.

SCHOOL BASED APPROACHES

School based curricula have included content that are designed to resolve certain social problems. Health classes commonly include content on drug abuse, sexually transmitted diseases and nutrition. Because of the risks posed by AIDS, guidelines for AIDS oriented health programs have been established (CDC, 1988).

School-based approaches will provide information about AIDS in relation to transmission, abstinence, and prevention. This content may be structured to stand alone, as part of sexually transmitted diseases, as part of sex education, or the health curriculum (Atlantic Information Services, Inc., 1988).

Changes in the level of AIDS knowledge, attitude and behavior among adolescents in San Francisco have been noted (DiClemente, Boyer & Mills, 1987). This result may be related to high visibility of AIDS in San Francisco.

School based approaches have not proven to be particularly successful as means of addressing problems experienced by adolescents (Flora & Thoresen, 1989; Kirby, 1985). However, some school based approaches designed to influence the rate of adolescent pregnancy have shown some promise (Gilchrist & Schinke, 1983; Schinke, 1984). Approaches that go beyond mere information giving to skill development are more likely to be successful.

MEDIA ORIENTED APPROACHES

Media are currently being used to transmit messages about AIDS. Television commercials, videos, newspapers, and newsletters are commonly used. Similar mechanisms have been used in attempts to reduce the rate of adolescent pregnancies. Media and school based approaches have not been totally successful ("Sex Ed. Impact," 1989; Flora & Thoreson, 1989).

Black teenagers represent 14% of the adolescent population, yet account for 28% of all adolescent pregnancies and 47% of births to unmarried teens (Children's Defense Fund, 1987). New approaches should be explored. A range of available approaches will permit the selection of

an approach that is most appropriate for a particular population group.

NEED TO IDENTIFY POTENTIAL COMPONENTS OF A FAMILY-BASED APPROACH

Significant behavior changes are more likely to come about when approaches that emphasize continuous feedback from skilled significant others are emphasized.

The family represents a context for socialization throughout the developmental cycle. Thus, there are multiple opportunities for informal teaching and learning among the family members. Both formal and informal approaches to teaching and learning can be developed and refined over time. Family oriented approaches will ensure the presence of cultural continuity among the participants. For example, language patterns, content, and behaviors common to the family are utilized in the communications process.

Family oriented approaches could become feasible for black parents who possess accurate knowledge and facilitative skills. The functional family perceives AIDS as a problem, is knowledgeable about AIDS, demonstrates coping skills and espouses a willingness to communicate with adolescent children. The existing status of black parents residing in public housing warrants attention. Knowledge about their status serves to identify gaps and limitations

within families. Interventive efforts could then be directed toward the identified deficits.

CHAPTER 11

RELEVANT ASPECTS OF THE LITERATURE

FAMILY SYSTEMS THEORY

Family systems theory explores the dynamics among members of a family unit. Concepts from this theory provide a framework for assessing the transactions between parents and children. It is possible to identify forces that either impede or promote functional exchanges (Minuchin, 1974). The quality, direction and timing of communication provide insights into dynamic patterns within the family unit. In preventing AIDS transmission among adolescents, it is necessary to identify those aspects of family functioning that might curtail their participation in high risk behaviors. All family members should be involved in the AIDS prevention process.

ECOLOGICAL - SYSTEMS THEORY

Ecological-systems theory stresses the relationship between the person and the human and non-human environments. The environment can either impede or promote individual and family growth (Germain & Gitterman, 1981). The environment can be modified to meet our needs. Our genetic potential

emerges within the context of a nurturing environment. Exchanges between people and their environment will ultimately determine the quality of an individual's functioning. When the environment is supportive, the individual is more likely to experience a sense of competency and self-worth. When the environment presents obstacles to optimal functioning, new coping skills are required. AIDS represents a threat within the external environment. Parents, through their socialization strategies are the first line of defense for teenagers, in the fight against AIDS.

The environmental contexts of black families will shape their responses to AIDS. Black inner-city families are often exposed to high crime rates, poverty, inadequate schools and drug related activities. Under such conditions, some families may not perceive AIDS as a priority. Available physical and human resources enhances the adolescent's potential for responding to perceived threat.

DEVELOPMENTAL THEORY

Developmental theories highlight the extent to which adolescents have the social, psychological, and cognitive maturity necessary for responding to complex demands from parents and other environmental sources.

AIDS prevention is dependent upon an ability to recognize high risk situations, followed by corrective

action. Such responses are, in part, contingent upon a capacity to carry out a situational assessment. Accurate knowledge is a requisite to such assessments. With a capacity for abstract thinking, adolescents are positioned, within limits, to assess their environment (Piaget, 1972). During early adolescence, ages 13 to 15, there is a tendency toward self-centered behavior (Zigler & Finn-Stevenson, 1987). Such behavior patterns may interfere with the adolescent's response to complexity.

Adolescents engage in a normative process of separating from their parents. Disengagement from parents may be manifested by a reduction in mutual activities, less communication, and disparate feelings (Montemayer, 1986). The pattern of separation has been found to be related to puberty. Parent-adolescent conflicts tend to co-vary with puberty (Steinberg & Hill, 1978; Hill, Holmbeck, Marlow, Green & Lynch, 1985b). The separation is in part, facilitated by peer acceptance. The adolescent's perceptions about what is required in order to achieve acceptance by peers may dictate the behavioral cycles that follows.

In addition, the adolescent's self-esteem is contingent upon internal and external factors (Sunenblick, 1988). Thus, engagement in risky behaviors may be a function of attempts to develop or maintain self-esteem. Esteem that is a function of peer acceptance and the

concomitant positive feelings, may play a dominant role in behavioral patterns.

COMMUNICATIONS THEORY

Assertiveness skills facilitate open communication. Thus, taboo subjects such as AIDS are more likely to be initiated by parents who possess such skills.

Adolescents who recognize non-verbal aspects of unassertiveness, such as a lack of eye contact or facial expression, may be unreceptive to the communicated messages.

Factors that might impede assertiveness are negative expectations and a belief that assertiveness is incorrect (Hepworth & Larsen, 1986).

When assertive behavior is accompanied by feelings of self-efficacy, a parent is more likely to engage his teenage child.

SELF-REINFORCEMENT THEORY

Self-reinforcement, a component of cognitive-behavioral theory, operates under the assumption that the individual can control his behavior through the use of rewards. Self-reinforcement is a means of strengthening and maintaining desirable behavior in the face of contradictory external reinforcement. Self-reinforcement may take the form of verbal praise or a tangible reward.

Assertiveness in communicating about AIDS must be reinforced. Self-reinforcement training has been found to be beneficial in helping people to play a role in maintaining desirable behaviors (Heiby, Ozaki & Campos, 1984).

When external support systems are weak or non-existent, self-reinforcement is likely to be used. Black families in urban areas may not have available support systems on a continuous basis. A modicum of self-reinforcement ability is essential to feelings of autonomy and competency.

PROBLEM-SOLVING THEORY

Families are faced with a variety of intra and extra familial problems for which there appears to be no solution. Without a method for problem analysis, instinctive efforts are unlikely to be successful. Problem-solving theory suggests a flexible process that leads to problem identification and solution. The process requires sharing, decision making and negotiation. In effect, problem-solving functions as a coping mechanism. Once learned, the process is a valuable resource for use with future obstacles.

People who perceive themselves as not possessing problem-solving skills are more likely to experience problems over time. People who perceive that they have such skills are eager to tackle problems and anticipate success (Heppner, P.P., Hibel, J.H., Neal, G.W., Weinstein, C.L., &

Rabinowitz, F.E., 1982). Problem-solving among families is beneficial to successful coping (Hepworth & Larsen, 1986).

Successful use of problem-solving skills by black parents and their teens may depend upon the context of application. However, black parents with perceived problem-solving skills are more likely to manifest attempts in communicating AIDS prevention messages.

Problem-solving involves both cognitive and behavioral tasks. Behavioral tasks are likely to be interactive with perceptions of self-efficacy. Perceived self-efficacy is a function of an individual's beliefs about his ability successfully negotiate obstacles. Therefore, perceived self-efficacy will, in part, determine one's level of investment in removing identified obstacles. Investments may take the form of effort, time, frequency or intensity (Bandura, 1980).

RESEARCH ON BLACK FAMILIES

Family theories explain how and why families function in various ways, and the relative effects of such functioning. The black family structure and functions are essential elements in task accomplishment.

Some have suggested that our approaches to researching Black families are, in part, responsible for existing perceptions. Conceptual frameworks that compare black families with white families result in a view that portrays

the black family as more pathological (Allen, 1978; Dilworth-Anderson & McAdoo, 1988). This framework has shaped the views of black families for a number of years. More recently, the strengths in black families have also been researched (Hill, 1971; Stack, 1975). The strengths function as resources for problem-solving. At the same time, challenges faced by black families that may adversely impact upon family life should not be discounted. But

recognition of the strengths and struggles within black families could facilitate development of useful family programs and policies.

BLACK FAMILY DYNAMICS AND ITS CONTEXT

Dynamics within black families include transactions with extended family members who are both biological and social (Hill, 1971; McAdoo, 1978). Social extended families are without biological ties but are given special prominence within the family.

The interrelationship between family structure and family dynamics is an important dimension. Expressive functions include social and emotional transactions within the family. Instrumental functions are those that are directed toward stabilizing the economic and physical state of the family (Blackwell, 1985). Expressive and instrumental functions are shared by both parents in black families (Billingsly, 1968). Greater access to the job

market by black women positioned them to perform instrumental tasks. Black men continue to have less access to jobs than their white counterparts. In single parent families, the black woman must perform both expressive and instrumental functions. As noted in (Levitan, Belous & Gallo, 1988), 42 percent of black families are headed by women.

Both expressive and instrumental functions are needed to achieve certain family goals. For example, functioning well in school requires the provision of shelter and clothing and parental motivation.

AIDS prevention strategies that emphasize both instrumental and expressive needs of adolescents are likely to be more effective. Black parents can transmit AIDS prevention messages within the context of caring, concern, support and economic and environmental integrity.

Black teens, particularly male adolescents are a prospective target of AIDS prevention messages. A majority, 97.2% of black male teens reside within families, nearly evenly distributed between single and two parent families. Found primarily in urban areas (83.2%), the black male adolescent is usually sexually active by age 19 (93.9%) (National Urban League, 1988).

Black male teens between the ages of 16-17 have the highest unemployment rate. A substantial proportion of black male teens are seeking full-time employment. Of

interest is that almost one-third of deaths among black male teens ages 15-19 are homicides (National Urban League, 1988).

Research and qualitative data indicate that black male adolescents are special risk group, therefore must be the target of interventive efforts. To date, current data locate the majority of black teens within a family structure. Thus, parents or parenting persons are positioned to provide assistance, support and comfort.

PARENT-CHILD TRANSACTIONS

Ethnographic studies have identified the extensive use of social support exchanges among extended family members in black families (Martin & Martin, 1978; Stack, 1974; Aschenbrenner, 1975; McAdoo, 1978). Thus, extended family members impact upon the attitudes and behaviors of adolescents within black families therefore should be included in family analyses.

Influencing desirable behaviors in children represent attempts at socialization. Noted within the black family is a tendency to use physical punishment as a form of social control (Ho, 1987; Peters, 1987), give greater sibling responsibility to the oldest child (Ho, 1987), and use meta communication (Ho, 1987). Meta communication is characterized by the use of commands embodied in facial expressions, voice pitch or tone. This pattern is in part,

designed to connote the importance of the message thereby influencing conformity. If meta messages influence conformity, then AIDS prevention messages to teens should follow this pattern.

Historically, black families have functioned to protect their children from threats associated with racism. For example, the reinforcement of identity through supportive statements; "black is beautiful" and a commitment to live within black neighborhoods. The child's chances of experiencing prejudice is effectively limited. Such dynamics are contextually functional and may be used for other goals.

Miller and Pittman (1982) concluded from their research that black families are more likely than white families to perceive their children as needing supervision. Children ages 6 to 16 were the subjects in this study. Families of lower socio-economic status were less likely to agree that supervision was unnecessary. This felt need to supervise their children implies a need to perform a protective function. If AIDS is perceived as a threat, black family members may act to protect the family unit.

SEXUAL SOCIALIZATION

A long standing function of the family is that of socializing its members. Sexual socialization results in the exercising of appropriate behaviors for sexual

functioning. The debate continues as to whether parents are more influential than age-graded peers as models of appropriate sexual behavior.

Same sex peers have been found to be a major source of information about sex (Miller, 1976; Thornburg, 1979). However, several studies suggests that despite the significance of peers, parents continue to play a role in the development of sexual behaviors among adolescents.

In a sample of black and white urban mothers, it was found that a majority of mothers had discussed birth control, sexual morality, dating, and menstruation with their children (Fox & Inazu, 1980). Parental normative beliefs were found to have limited effects in the decision to become sexually active, but have considerable impact upon later contraceptive use (Baker, Thalberg, & Morrison, 1988). Flick (1986), found that as parental supervision decreases, sexual activity increases.

Parental supervision is often not available in black single parent families where the parent is employed. Children in these families are without continuous or consistent supervision during critical periods, for example, immediately after school. Opportunities to engage in high risk behaviors exist when parents are unavailable.

In general, it appears that the role of parents as formal sex educators is small but significant. Mothers are more often involved in educating their daughters about sex.

Traditionally, mothers have served as nurturers within the family and often engage in efforts to protect their children. Given this role, women are more likely to seek out the knowledge needed to help their children. In addition, black families are more likely to be female headed. Thus, females are responsible for sexual socialization in many instances.

Black children are likely to be the recipient of three distinct sexual messages; those of ambivalence, fear and anger, and sexual openness (Devore & Schlesinger, 1987). Multiple messages that appear to conflict with one another lead to dysfunctional responses. For example, when both anger and sexual openness are expressed by a parent, the adolescent's sexual identity may be weakened. Thus, the adolescent may engage in risky sexual behavior while seeking to develop a renewed identity.

AIDS ATTITUDE AND KNOWLEDGE GAPS

With respect to AIDS, knowledge is a necessary but not sufficient antecedent to behavior modification (Keegles, Adler & Irwin, 1988).

Knowledge, attitude, and behavioral deficits have been found in black adults and adolescents. A San Francisco survey found that blacks exhibited deficits about how AIDS is spread from one person to another, what constitutes

unsafe sex, and the meaning of a positive or negative antibody test (Polaris Research and Development, 1987).

The National Center for Health Statistics has conducted regular surveys on AIDS knowledge and attitudes among Americans since 1987. Random samples were used, therefore blacks were included in these surveys. A special report on the knowledge and attitudes of blacks was issued in March, 1989. The report indicated that the knowledge and attitudinal patterns of blacks were no difference from those of the general population. Age, educational and gender responses were quite consistent with the general pattern (Dawson & Hardy, 1989).

When specific areas of knowledge were analyzed, differences between blacks and whites were noted. With respect to AIDS transmission, blacks were more likely to attribute risks to casual contacts. With respect to general AIDS knowledge, blacks were less knowledgeable in some areas, namely, that AIDS reduces the body's ability to fight diseases and that one can have the virus and not have AIDS. As for the effectiveness of condoms in preventing AIDS, 47% viewed this method as only somewhat effective (Dawson & Hardy, 1989). Variability by age and education were also noted in this research. No significant gender variability was reported.

Keegles, Adler, & Irwin (1988), reported that while adolescents were aware that condoms could be used to prevent

the spread of sexually transmitted diseases, increased use was not found. In a study of the contraceptive knowledge, attitude, and behaviors of black adolescent males, it was determined that many respondents felt that sex should be spontaneous (Leonard, 1988). Implied here is the notion that contraceptive use tends to interfere with spontaneity.

Unevenness in knowledge about AIDS among adolescents was found in San Francisco, a high risk city (DiClemente, Zorn, & Temoshok, 1986). In a subsequent study of black, white, and latino youths, it was found that black and latino youths demonstrated a higher level of misconceptions about the causes of AIDS than did white youths (DiClemente et. al., 1988). Similar deficiencies were found in other studies of adolescents (Hingson, 1987; Price, DeMong, & Kukulka, 1985; Sunenblick, 1988). Such unevenness in knowledge may lead to increased participation in high risk behaviors.

BLACK PARENTING INTERVENTION PROGRAMS

Parent training as a mode of preventive intervention is designed to provide knowledge and skills needed for effective parenting. According to Stevens (1988), the ability of black parents to function optimally is dependent upon locus of control. Feelings of autonomy and self-determination were also significantly correlated with an ability to stimulate children.

Prior studies of programs designed to enhance the development of parenting skills among black parents indicated that such programs are beneficial for skill development (Durrett, Bryant & Pennebaker, 1975; Baumring, 1975; Levine & Bartz, 1979). Alvy (1988), has proposed that parenting programs should be designed to meet the specific needs of blacks. Such programs should include topics as developing self-esteem, developing sexually responsible children, stimulating academic growth, single parenting and black self-discipline.

A recent study sought to evaluate the views of parents toward an " AIDS Education for Parents of Adolescent Children Program " (Communication Technologies, 1988). The study concluded that parents recognized the value of education as a significant factor in the fight against AIDS. The parents also expressed a concern for the health of their children.

Interventions directed toward black parents should recognize the continuing relationship between parents and their adolescent children, build upon the parent's need to perform protective functions, be cognizant of the knowledge deficiencies in adolescents and parents about AIDS and recognize the extent to which culture will shape the responses by parents.

**RATIONALE FOR ASSESSING THE POTENTIAL OF BLACK PARENTS IN
PUBLIC HOUSING TO TRANSMIT AIDS PREVENTION MESSAGES**

Identified high risks groups among blacks include women, unborn children, homosexual and bisexual males and IV drug users. The physical and social environments inhabited by high risk groups exhibit numerous socioeconomic problems. Public housing projects in New York city are characterized by poverty, crime and drug trafficking. Black youths in New York City experience higher rates of adolescent pregnancies, early sexual experiences, and high school dropout when compared with their white counterparts. These conditions exacerbate existing risks and contribute to an environment where AIDS transmission can flourish among black adolescents. Inappropriate behaviors are likely to be modelled for impressionable youths. Moreover, high school dropouts and pregnant teens are diverted from educational resources that could provide accurate knowledge about AIDS prevention.

Possession of accurate knowledge about AIDS and facilitative skills are perceived as significant to effective parent-teen communication. There exist, numerous studies that sought to assess the level of AIDS knowledge among adolescents and their parents. Knowledge gaps and misconceptions were identified. However, few studies have focused specifically upon black Americans. To date, no available studies have sought to correlate AIDS knowledge

and specified cognitive-behavioral skills within an inner-city black population living in a public housing project.

New interventive efforts are required to minimize the threat of AIDS. By virtue of their status as caretakers, black parents must play a role in preventing AIDS among their teenage children. But, before new efforts are developed, an evaluation of parental potential to function in this role is needed. Black parents from inner-city public housing projects warrant special attention.

CHAPTER 111**STUDY DESIGN AND METHODOLOGY****FOCUS GROUPS**

Because prior work on AIDS and black residents of inner-city public housing was not available, a preliminary examination of this population subgroup was warranted. In addition, perceptions flowing from the black community indicated that accessing this group might be problematic. For example, AIDS is perceived by some blacks as a form of genocide inflicted upon them by the majority community. Other blacks perceived AIDS as a disease of white homosexuals.

Needed was a method which would provide initial access to the feelings and perceptions of black residents of public housing. The focus group offered this possibility. Three focus groups from the upper west side of the borough of Manhattan were involved in my preliminary efforts. Members were recruited through the tenants association of two housing projects. Each participant was paid a fee of \$20.00. Each group consisted of six to twelve members who were primarily female and black. The participants ranged in age from about the mid twenties to mid sixties. The group sessions were conducted during the late afternoon and early

evening in order to maximize opportunities for participation.

Issues and questions from the areas listed below were discussed.

1. What are the major social problems in this community?
2. Is there a drug problem in this community?
3. Do you discuss AIDS with your children?
4. Is there a relationship between AIDS and use of crack cocaine?
5. Should there be programs to teach parents how to discuss AIDS with their teenage children?
6. What are some of the causes of AIDS?
7. What resources exist to combat AIDS?
8. Strengths needed in order to persist with children.
9. Sources of help within the black community.

In summary, the participants recognized AIDS and drugs as problems needing immediate attention. Teenagers were identified as being at high risk of AIDS. Parents were accepting of programs designed to help parents learn how to communicate with their children about AIDS and sex. Parents were aware of the lack of support by churches, schools, and other role models. Some parents expressed fear of their children, while others perceived children as being more knowledgeable about AIDS than adults. Adults are generally perceived to be resistant in discussing AIDS with their

children on a continuous basis. Clues to needed cognitive-behavioral skills were communicated during the focus group sessions. Group members stated that there were obstacles to discussing AIDS with their children. Identified obstacles are fear and inadequate knowledge. Some group members noted that too few external sources of support exist within the community and that continuous efforts are necessary to combat AIDS.

KEY VARIABLES AND DEFINITIONS

This study rests upon three basic assumptions:

1. Parents who perceive their teenage children to be at risk of AIDS will act to protect them.
2. Parents without accurate knowledge will not be able to respond to their children in an appropriate manner.
3. When threatening/taboo topics are at issue, parents must possess skills that have the potential for neutralizing the effects of this content. Among the necessary skills are a perceived problem-solving ability, assertiveness, and self-reinforcement.

Independent and dependent variables, and their operational definitions are described next.

INDEPENDENT VARIABLES AND DEFINITIONS

1. Education: Highest level of education identified by the respondent during the initial contact.

1. None
2. Grade School
3. Some High School
4. GED
5. Some College
6. Graduated College

2. Black family: A biological unit with teenage children between the ages of 13 and 18. Aunts, uncles, and grandparents may also function as parents in these units.

3. Gender: Male or female as identified during initial contact

DEPENDENT VARIABLES

1. General AIDS knowledge: General knowledge of AIDS as measured by a general knowledge subscale.
2. Knowledge of AIDS prevention: Knowledge of AIDS prevention as measured by a knowledge of AIDS prevention subscale.
3. Knowledge of AIDS transmission: Knowledge of AIDS transmission as measured by a knowledge AIDS transmission scale.
4. Skills in self-reinforcement: Level of skill as measured by a Frequency of Self-Reinforcement Scale.

5. Perceived problem-solving ability: Perceived ability to solve problems as measured by a Problem-Solving Inventory.

6. Assertiveness Skills: Level of assertiveness skill as measured by the Simple Rathus Assertiveness Inventory.

HYPOTHESES

The following hypotheses are advanced:

H₁ Black parents from inner-city housing projects obtain lower percentage of correct responses to the knowledge of AIDS transmission and prevention scales than Blacks in the general Population.

H₂ Female household heads will demonstrate higher levels of knowledge of AIDS transmission and prevention than male heads.

H₃ Knowledge of AIDS transmission and prevention will vary by education.

H₄ General AIDS knowledge will vary positively with the cognitive-behavioral skills of assertiveness, perceived problem-solving ability and frequency of self-reinforcement.

H₅ Knowledge of AIDS transmission and prevention will vary with the cognitive-behavioral skills of assertiveness, perceived problem-solving ability and frequency of self-reinforcement.

H₆ Perceived comfort in discussing AIDS and sex with children will vary with the cognitive-behavioral skills of assertiveness, perceived problem-solving ability and frequency of self-reinforcement.

SITE SELECTION

Potential sites for the study were evaluated by two standards, 1) that a willingness to cooperate is signaled by both the management and Tenant Association and 2) a substantial black population be present. A total of four sites in Manhattan, New York were contacted and assessed. A single site was selected and a relationship with the Tenants Association president and Board was developed.

Initial entry into this housing project was facilitated through local management. While supportive of the aims of the study, the manager noted that existing housing regulations would not permit access to a listing of current tenants. Subsequent networking with board members and the Tenants Association President, resulted in an interest in and a verbal commitment to assist with an orientation to the population and sample acquisition.

The selected site, located in central Harlem, has 2300 units dispersed throughout nine buildings. Residents are predominantly black and Hispanic and must conform to certain preconditions for entry, including income and family size guidelines. According to the manager, the maximum earnings

permitted is about \$33,000 dollars, however only a few families have incomes at that level. Such families are likely to be large with more than one wage earner or may be subject to a surcharge.

SAMPLE SELECTION

The sample for the study was recruited through written flyers and verbal announcements made at tenants association meetings during the period June-August, 1989. Families were screened and selected based upon three criteria, 1) that they reside in the housing project 2) that they be black and 3) that they have teenage children between the ages of 13 and 18. An available sampling method was employed because of a lack of access to a listing of all families within the housing project as well as anecdotal knowledge, reflecting resistance to discussing AIDS related content within the black community.

Because of their expressed interest in and meeting of specified criteria, 129 household heads, each representing a black family, were selected for this study. The sample consists of 48 male and 81 female heads, for a total $N=129$. Immediately following their selection, each household head was interviewed.

INSTRUMENTATION AND DATA COLLECTION PROCEDURES

Several scales were selected for use. The nature and utility of each scale follows:

1.Measurement of AIDS knowledge and attitude.

The level of AIDS knowledge possessed by black parents was attained through the use of a 55 item survey instrument containing several subscales. The instrument is a modified version of an instrument developed for assessing the level of AIDS knowledge within the general population (Dawson, D. & Hardy, A., 1988).

From the original instrument, nineteen items were deleted as they were not pertinent to the aims of the study. Added were items designed to obtain data regarding use of drugs, awareness of drug use within the community, and perceived comfort level in discussing AIDS, drugs, and sex with children and other parents.

Three areas of AIDS knowledge are pertinent to this study, general knowledge, knowledge of transmission, and prevention. General AIDS knowledge is measured in a 14 item subscale. Good reliability is reported, alpha .78 (Dawson, 1989). Knowledge of transmission is measured through an 11 item subscale. Good reliability is also reported, alpha .88 (Dawson, 1989). Knowledge of prevention is measured through a five-item subscale.

2.Cognitive-behavioral skills.

A. The problem-solving potential of each parent was assessed. The problem-solving perceptions of parents were assessed through the use of The Problem-Solving Inventory (Heppner, P.P. & C.H. Peterson, 1982). The 35 item self-scoring scale assessed the individual's beliefs about how he/she reacts to personal problems. Three subscales, problem-solving confidence, approach-avoidance and personal control are included. Each subscale can be scored independently in order to highlight specific aspects of perceived problem-solving ability. An overall index to one's problem-solving perception is achieved when all scores are totalled. Lower scores are reflective of better perceived problem-solving ability.

Internal consistency, as demonstrated by alphas of .72 to .85 on the subscales and .90 on the total measure, is quite adequate. Good concurrent and construct validity were also reported

B. The Frequency of Self-Reinforcement scale, containing 30 items, was used to determine the self-reinforcement pattern of parents. The instrument assessed the extent to which one support, encourage, or value one's efforts (Heiby, E.M., 1983).

Internal consistency is high (alpha .87). Stability is high, with an eight-week test-retest correlation of .92. Good concurrent and construct validity were also reported by the author of this instrument. Scoring can range up to 90

points. The higher scores are reflective of greater use of self-reinforcement. Significant lacks in the use of self-reinforcement are reflected in scores below 16. The individual is perceived to very dependent upon others for approval (Heiby, E.M., 1983).

C. The degree of assertiveness by parents was determined through the use of the 30-item Simple Rathus Assertiveness Schedule (McCormick, I.A., 1984). Internal consistency is .90 as determined with odd-even correlations. All items are scored and summed. Scores can range from 30 to 180. Higher scores are reflective of higher levels of assertiveness.

FIELD TESTING OF INSTRUMENTS

All instruments were field tested using Black parents from a housing project located about 2 miles from the site selected for study. Scales were administered within the apartments of selected participants. The Tenants Association assisted in locating participants. Each household head (parent) was provided an incentive of \$10.00 upon completion of the instrument.

Slight modification of content resulted from the field tests. Also of concern was the amount of time needed for completion of the instrument. From one and one-half to two hours were needed. Thus, a decision was made to allow a ten

minute break, between the administration of each scale, in order to reduce tiring.

INTERVIEWER TRAINING

All interviewers were experienced, having worked on other studies related to AIDS and blacks, where extensive interviewer training was provided over a period of four weeks. During this four week period, they developed general interviewing skills as well as skills related to face to face interviews.

For this study, a four-hour training/orientation session was conducted in order to reinforce existing skills and enhance consistency in performance. Interviewers gained familiarity with the interview guide and the protocol for initial screening of interested participants. Through simulated practice, the participants were able to experience the demands of the data collection process. Particular emphasis was paid to energy level and time demands.

DATA COLLECTION

Black interviewers, three women and two men, including the investigator, were used to administer the questionnaire. Based upon anecdotal accounts, some resistance was anticipated by parents around the subject of AIDS. Some members of the black community adhere to the belief that AIDS was invented by the majority culture to destroy blacks

(Schilling, Schinke, et al., 1989). Minority interviewers were used to minimize resistance.

Using a preplanned protocol, interested participants were screened using the criteria stated elsewhere. Approximately 225 household heads were screened, culminating in an N of 129 over a period of twelve weeks. In order to minimize contamination, the interview sight was rotated among the building within the housing complex. This practice also served to diversify the subjects, as representatives from other buildings participated in the study.

Interviews were conducted from June through August, 1989 during the day, early evening, and on week-ends in order to enhance the quality of the sample. Such a strategy also served to ensure a more representative sample of residents. The physical environment for the interviews consisted of tables in a relatively large room located in the basement. Total privacy was not possible due to the nature of the test site. Instrument 1 was administered by the interviewer. Instruments 2-4 were self-administered in the presence of the interviewer. Instruments were administered in the following sequence: AIDS Knowledge and Attitude Scale; The Problem-Solving Inventory; Simple Rathus Assertiveness Inventory; and Frequency of Self-Reinforcement Scale.

Upon completion of the interview, each respondent read and signed a consent to participate, after which, was given a fee of \$10.00 in recognition of the value of their time.

DATA ANALYSIS

Data were analyzed using descriptive statistics such as the mean, median, mode and standard deviation. Selected findings were compared with national data sets on black Americans and AIDS. Correlation analysis was used to determine whether there exists relationships between AIDS knowledge and demographic variables (Education), as well as cognitive-behavioral skills (perceived problem-solving ability, assertiveness, self-reinforcement).

The t-test was used to evaluate the possibility of gender differences and AIDS knowledge.

CHAPTER 1V

FINDINGS:DESCRIPTION OF SAMPLE

This chapter will describe socio-demographic characteristics of the sample, and AIDS related findings pertinent to the aims of the study. These findings will be discussed through out the remaining chapters.

The study sample consists of one-hundred and twenty-nine black, adult household heads, currently residing in a public housing project. The housing complex is located in central Harlem, an urban community in New York city.

SOCIODEMOGRAPHIC CHARACTERISTICS

The subject's level of education, income, marital status, age, size of household, ethnicity, gender, source of income and place of birth follows.

EDUCATION

Sixty-five percent of the sample has either completed high school, obtained a GED or had some college experience. The mean level of education is 4.27 (S.D.= 1.31) (See Table 4-1). However, 31 % (40) did not complete high school.

Fifty percent of the sample ($N=64$) have vocational training.

TABLE 4-1

EDUCATION LEVELS AMONG THE STUDY SAMPLE

<u>EDUCATIONAL LEVELS</u>	<u>N</u>	<u>VALID PERCENT</u>
None	1	.8
Grade school	4	3.1
Some high school	35	27.1
Graduated high school	47	36.4
GED	8	6.2
Some college	29	22.5
Graduated college	5	3.9
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Total	129	100.0

INCOME AND SOURCES

The mean bi-weekly take home income for the sample is \$369.70 (S.D.= 280) (median income = \$285; mode=\$600). The mean annual income for the sample is \$10,781(S.D.=9296) (median=\$7200; mode=\$15000).

Sixty-two point nine percent of the families earned less than \$10,400.00 during the last year, placing them well below the national poverty rate of 11,600.10 for the year 1989. For 1987, the median income for black married couple families was \$27,180 and for female headed families \$9,710 (U.S.Department of Commerce, 1988).

Almost 43% of the sample reported welfare as their source of income. About 50% reported other, a category including employment. (See Table 4-2).

TABLE 4-2

SOURCES OF INCOME FOR STUDY SAMPLE		
<u>Sources</u>	<u>N</u>	<u>Valid Percent</u>
Unemployment benefits	2	1.6
Disability benefits	3	2.3
Welfare, food stamps	55	42.6
* Other	64	49.6
None	5	3.9
Total percent of sample	129	100

* Includes employment and cash contributions

GENDER, AGE AND ETHNICITY

The study sample consists of 62.8% (N=81) females and 37.2%

(N=48) males. The mean age of the sample is 36.884 years (S.D. =9) (median = 35; mode=31).

The sample is predominantly African American (95.3%; N=123), with small numbers of Haitians and Jamaicans.

MARITAL STATUS

Thirty-five point seven percent (46) of the respondents are single never married, 24% (31) are married, 22.5% (29) are separated, 9.3% (12) are divorced, 4.7% (6) are widowed and 3.9% (5) are living with a significant other (see Table

4-3). A total of 67.5% (87) are either single, separated, or divorced.

TABLE 4-3

SUMMARY OF MARITAL STATUS FOR SAMPLE

<u>Status</u>	<u>N</u>	<u>Valid Percent</u>
Single	46	35.7
Married	31	24.0
Separated	29	22.5
Divorced	12	9.3
Widowed	6	4.7
Living with sig. other	5	3.9
Total	129	100.0

SIZE OF HOUSEHOLDS

The mean household size is 4.13 occupants with a range between 1 and 10 (median=4; mode=3; SD=1.55).

RELATIONSHIPS AMONG HOUSEHOLD MEMBERS

The household heads(ss) reported on their relationship to other members of the household. Only 15.6% (20) of the respondents reported that either a mother or father resides in the household. Thus, there is very little evidence of extended family members existing in the households (see Table 4-4).

TABLE 4-4

KINSHIP PATTERNS AMONG HOUSEHOLD MEMBERS

<u>Status</u>	<u>N</u>	<u>Valid Percent</u>
Father	3	2.3
Mother	17	13.2
Sibling	9	7.0
Aunt, uncle, nep, ni.	3	2.3
Spouse	26	20.2
Friend	2	1.6
Children	54	41.9
Grand children	4	3.1
Significant other	10	7.8
Other	1	.8

Total	129	100.0
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SUMMARY

What emerges is a fairly diverse sample with a mixture of families representing a range on the economic continuum. The families represent a departure from the general population in terms of size (mean = 4.13, SD = 1.55), and are headed by individuals that are relatively young (mean = 36.8, SD = 9). Although 42.6% of the families receive assistance from public welfare, 49.6% reported their income source as other which includes employment. The estimated annual income (mean = 10,781.73, SD = 9296.83) for the families is well below the national poverty level.

More than 72% of the household heads are either single, separated, divorced or widowed. Educational levels spanned the gamut, with 31% not completing high school, 36.4%

completed high school, 22.5% with some college experience, and 3.9% having graduated.

There is little evidence of extended families members existing within the households. Only 17.9% of the sample reported having either a mother, father, aunt or uncle living within the household. An identified strength of the black family has been its ability to fuse others into the family structure (Hill, 1972).

In spite of the absence of a random selection, the sample, is diverse by size, income, education and income sources.

PERTINENT AIDS RELATED DESCRIPTIVE FINDINGS

PERCEIVED KNOWLEDGE OF AIDS

When asked, "how much would you say you know about AIDS," a majority, 51.2 % of the sample professed to have some knowledge of AIDS. However, 16.3 % reported having "a lot" of knowledge and 32.4 % reported having "a little." The 32.4 % reporting "a little" knowledge about AIDS implies a recognized deficit, and thus some potential need for increased knowledge.

TEENAGERS ACCESS TO AIDS KNOWLEDGE

Access to knowledge of AIDS by teenagers is of import to this study. When asked, "Has this child/Have any or all

of your children ages 13 through 18 had instruction at school about AIDS," 56.6 % reported yes. Another 9.3 % reported no and 34.1 % reported, do not know. The 34.1 % reporting "do not know" is a significant percentage and suggests a need for intervention in this area.

PARENTAL ACCESS TO AIDS KNOWLEDGE

Parental access to AIDS knowledge impacts upon the question of readiness to transmit AIDS knowledge to their teenage children. Five items illustrates reported access.

When asked, "In the past month, have you seen any public service announcements about AIDS on television," 83.7 % reported, "yes," 13.2 % reported "no," about 3.1 % reported, "do not know." When asked, "In the past month, have you heard any public service announcements about AIDS on radio," 57.4 % reported "yes," 38.8 % reported "no," and 2.3 % reported "do not know." Data collected on a national sample black Americans during May-October 1988 revealed that 86% of black Americans had seen public service announcements about AIDS on television. About 51% had heard such announcements on radio (Dawson & Hardy, 1989).

The available data indicate that both radio and television are viable sources of AIDS knowledge. A substantial proportion of all samples have identified these sources as being available to them. Thus, radio and

television should remain as components of current interventive efforts.

When asked, "In the past month, have you read any brochures or pamphlets about AIDS," 58.1 % reported "yes," 39.8 % reported "no," and 2.3 % reported "do not know." When asked, "Have you ever read any brochures or pamphlets about AIDS," 81.4 % reported "yes." Another 18.6 % reported "no." A large proportion of the sample has had some access to AIDS knowledge. These findings exceed those reported for a national sample of Americans; where only 23% reported having read brochures or pamphlets during the previous month. About 62% reported having read such materials at some other time in the past (Hardy, 1989).

DISCUSSION ABOUT AIDS WITH TEENAGE CHILDREN

When asked, "Have you ever discussed AIDS with this child/any of your children ages 13 through 18," 79.8 % reported "yes," and 20.2 % reported, "no." A majority of parents in this sample espoused conveying AIDS information to their teenage children. The nature, extent and frequency of these informational contacts are not known.

PERCEIVED DRUG USE BY COMMUNITY TEENS

When asked, "During the past three months, how often have you heard of teenagers in your community using crack," a majority of the respondents (84.5%) reported "many times."

Implied here is the existence of high visibility drug use on the part of teenagers. Such a level of visibility may create a high level of consciousness regarding the threat of AIDS. Parents who participated in the focus groups were aware of the linkages between AIDS and drugs (Focus Group Sessions, April, 1989).

PERSONAL KNOWLEDGE OF PERSONS WITH AIDS

When asked, "Have you ever personally known anyone with AIDS or the AIDS virus," 50.4% reported " yes." Of the 50.4%, 31.1% indicated the they knew the person with AIDS very well, 20.1% fairly well.

PARENTAL RISK FACTORS

In addition to inaccurate knowledge, a percentage of the sample demonstrated several risk factors. Use of a sexually transmitted disease clinic was reported by 9.3% of the respondents. Of reported drug use by the respondents, 4.2% consumed heroin, 13.5% consumed cocaine and 5.7% consumed crack, (N = 129).

SUMMARY

Subjects in this sample projected an awareness of the presence of AIDS and drugs in their immediate environment. Concomitant with this awareness is a moderate level of perceived self-knowledge about AIDS. A majority had

discussed AIDS with their teenage children. Multiple sources of AIDS information were identified for both parents and teens. Over 50% of the parents in the public housing sample personally knew someone with AIDS or the AIDS virus. Such exposure may motivate the parents to engage in preventive activity. However, this finding may not suggest that there exist a disproportionate number of AIDS cases within the housing project. But, that the subjects are exposed to many of the same victims. The housing project represents a community with well defined boundaries.

Thus, their environmental experiences and espoused willingness to discuss AIDS and drugs with their children suggest readiness to transmit AIDS prevention messages. These families may exhibit readiness because of felt pressure from the housing project environment.

CHAPTER V

FINDINGS: AIDS KNOWLEDGE AND ATTITUDES

This chapter has two purposes: to examine the level of AIDS knowledge of transmission and prevention within a sample of black residents of an inner-city housing project and compare with a national sample of blacks; and to identify specific differences on all items measuring knowledge of AIDS transmission and prevention for both the public housing sample (BFPH;N=129) and national sample of black Americans (NSBA;N=3,086).

H₁ Black parents from inner-city housing projects obtain lower percentage of correct responses to the knowledge of AIDS transmission and prevention scales than blacks in the general population.

Three subscales were used to assess the actual level of AIDS knowledge within the sample. Knowledge level is demonstrated in three areas; general knowledge-fourteen items, knowledge of AIDS transmission-eleven items, and knowledge of prevention-five items. Each area of knowledge is analyzed separately specifying the percentage of correct

items on each scale. However, the hypothesis is concerned about knowledge of transmission and prevention only.

Selected findings on general AIDS knowledge, are compared with previous findings within a national sample of black Americans, hereafter referred to as (NSBA).

GENERAL KNOWLEDGE

Fourteen items are included in the general AIDS knowledge scale. The mean number of correct items is 8.83 (SD=2.63.) (median=9:mode=10). Twenty point two percent of the sample chose 6 or fewer correct responses. Fewer than 10 correct responses were reflected in the performance of 72.9% of the sample. The sample reflects a relatively high level of AIDS general knowledge (mean = 8.83 correct answers). However, there exist deficits around specific areas of knowledge.

A further look at individual items indicates that 41.9% of the sample were not aware there exist a difference between the AIDS virus and the disease itself.

Approximately twenty percent of the sample were not aware that infected persons could look and feel well. This lack will enhance the risk of exposure to AIDS by reducing the perceived need to take precautions based on overt appearance. Fourteen point seven percent of the sample reported that it was either definitely true or probably true

that a vaccine exist to protect individuals against AIDS. Misperceptions lead to high risk behaviors that increases one's chances of getting AIDS. A belief that a vaccine exists may serve to decrease one's level of awareness about the potential for acquiring AIDS.

Noteworthy is that 98.4% of the sample were aware that pregnant women could give the AIDS virus to their baby. The national sample of black Americans (NSBA) did not respond as well. However, the percentage of correct responses varied with education. For sample members with less than 12 years of education, 72% responded correctly. Those subjects with 12 years and more than 12 years demonstrated an 82% correct response rate (Dawson & Hardy, 1989).

Ninety-six point nine percent of the black families in public housing (hereafter referred to as BFPH), believed that it was either definitely true or probably true that the AIDS virus can be transmitted through sexual intercourse, compared to ninety-three percent in the NSBA sample (Dawson & Hardy, 1989). Ninety-four point six percent of the BFPH sample believed that it was either definitely true or probably true that AIDS is an infectious disease caused by a virus. In the NSBA sample, only 78% shared the same belief.

KNOWLEDGE OF AIDS TRANSMISSION

Knowledge of how AIDS is transmitted is demonstrated through responses to an 11 item scale. The scale reflects the current state of knowledge about AIDS transmission.

Knowledge of transmission is perceived as a prerequisite to reducing one's level of participation in high risk behavior. High risk behaviors are those behavior that are likely to promote the transmission of AIDS to another. The exchange of bodily fluids through sexual or drug related activities are given the most attention.

The following frequency distribution illustrates how members of the sample responded to the AIDS transmission scale. Both "very unlikely and definitely not possible" are acceptable responses for items 20-a through g, i to k. A response of "very likely" is appropriate for item 20-h.

TABLE-5-1

 RESPONSES ON AIDS TRANSMISSION SCALE

NUMBER OF CORRECT ITEMS	N	PERCENT	CUMULATIVE PCT.
.00	2	1.6	1.6
1.00	16	12.4	14.0
2.00	13	10.1	24.0
3.00	10	7.8	31.8
4.00	16	12.4	44.2
5.00	10	7.8	51.9
6.00	17	13.2	65.1
7.00	12	9.3	74.4
8.00	10	7.8	82.2
9.00	14	10.9	93.0
10.00	4	3.1	96.1
11.00	5	3.9	100.0
TOTALS	129	100.0	

The mean number of correct responses for the sample is 5.21 (SD = 2.97; mode = 6, median = 5). Only 3.9% of the sample provided correct responses to all items and 1.6% was unable to provide correct responses to any of the items. Of significance is that 56.9% of the sample selected five or fewer correct responses (see Table 5-1).

This low response rate demonstrates a lack of knowledge about AIDS transmission. Misconceptions about AIDS transmission can lead to high risk behavior. Uninformed parents are not well positioned to provide their teenage children with the AIDS knowledge necessary for corrective action.

DISCUSSION OF TRANSMISSION ITEMS AND COMPARISONS WITH NATIONAL SAMPLE

A closer analysis of individual items will identify areas for intervention. When asked; How likely do you think it is that a person will get AIDS or the AIDS virus from:

1. Living near a hospital or home for AIDS patients.

Approximately 34% of the BFPH sample thought it very unlikely and 25.6% thought it definitely not possible. Some 20.9% thought it very likely or somewhat likely (see Table 5-2).

A national sample of black Americans (NSBA) presented 37 and 33% respectively (Dawson & Hardy, 1989).

2. Working near someone with the AIDS virus.

Twenty-nine point five percent of the BFPH sample thought it very unlikely and 20.2% thought it definitely not possible. Some 28.7% of the sample thought it was either very likely or somewhat likely (see Table 5-2).

The NSBA sample responded at 34 and 25% respectively (Dawson & Hardy, 1989). Definitive responses vary by 4.8 percentage point within both samples. Of greater concern is the 28.7% of the BFPH sample who thought it was either very likely or somewhat likely. Such beliefs will lead to inappropriate social interaction with persons with AIDS. Discriminatory practices are likely to occur.

3. Eating in a restaurant where the cook has the virus.

About 17% of the BFPH sample studied thought it very unlikely and fourteen percent thought it definitely not possible. However, 38% of the sample thought it was either very likely or somewhat likely (See table 5-2).

A national sample of black American responded at 24 and 14% respectively (Dawson & Hardy, 1989).

Within the two black samples, a large disparity is noted in the very unlikely responses. A spread of seven percentage points is noted, with the NSBA sample blacks scoring better than the BFPH sample.

4. Kissing-with exchange of saliva-a person who has the AIDS virus.

Nearly 11% of the sample responded, very unlikely and 6.2%, definitely not possible. Some 39.5% responded, very likely, 24.8%, somewhat likely (See table 5-2).

In the NSBA sample, 24% responded at the very unlikely level and 14% indicated, definitely not possible (Dawson & Hardy, 1989).

Both samples projected a strong belief that AIDS is transmitted through kissing, with an exchange of saliva. Perhaps this perception is based upon the closeness of contact implied in kissing. The samples also varied substantially from the acceptable responses, of either

"very unlikely" or "definitely not possible"; established by the National Center for Health Statistics (Dawson, 1989).

5. Shaking hands, touching, or kissing on the cheek, someone who has the AIDS virus.

Of the BFPH sample 33.3% responded, very unlikely, 29.5%, definitely not possible. Some 17.8% believed that it was either very likely or somewhat likely that AIDS is transmitted through shaking hands, touching, or kissing someone on the cheek.

The NSBA believed that it was very unlikely (35%), definitely not possible, (27%), that AIDS is transmitted through shaking hands, touching, or kissing someone on the cheek (Dawson & Hardy, 1989).

The NSBA sample and the BFPH sample responded similarly.

6. Sharing plates, forks, or glasses with someone who has the AIDS virus.

Twenty-four percent of the BFPH sample responded at the very unlikely level, with 17.8% believing that is definitely not possible that AIDS is transmitted when sharing plates, forks, or glasses with someone who has the AIDS virus. A strong proportion, 31.8%, believed that it is either very likely or somewhat likely (see Table 5.2).

The NSBA varied, substantially from BFPH. Thirty-five percent of the NSBA sample thought that it was very unlikely or definitely not possible (Dawson & Hardy, 1989).

7.Using Public toilets.

About 20.9% of the BFPH sample responded at the very unlikely level, with 17.8% believing that it is definitely not possible. Of significance is that 31.8% believed that it is either very likely or somewhat likely that AIDS is transmitted when using public toilets (see Table 5-2).

The NSBA showed a 24% response rate at the very unlikely level and a 16% at the definitely not possible level. The very likely and somewhat likely response levels showed a 33% response rate. Some 15% responded, don't know (Dawson & Hardy, 1989).

Misconceptions exist in both of the black samples, as reflected by the 31.8 and 33% who thought that one could contract AIDS when using public toilets.

8.Sharing needles for drug use with someone who has the AIDS virus.

A high rate of correct responses are reflected in all samples; 95.5% among BFPH and 91% in the NSBA sample.

9.Being coughed or sneezed on by someone who has the AIDS virus. Of the BFPH sample, 27.1% believed that it is very

unlikely that AIDS is transmitted when coughed or sneezed on by someone who has the AIDS virus. About 10.9% believed that it is definitely not possible. A large proportion, 40.3%, believed that it is either likely or somewhat likely (see Table 5.2). Thus, a notable level of misconceptions about this mode of transmission is demonstrated.

The NSBA sample (23%) compare favorably with the BFPH sample in the very unlikely response level. Fourteen percent believed that it is definitely not possible (Dawson & Hardy, 1989).

10. Attending school with a child who has the AIDS virus.

Almost 36% of the BFPH sample believed that it is very unlikely that AIDS is transmitted when attending school with a child who has the AIDS virus, 19.4% believed that it is definitely not possible. However, 17.8% believed that it is very likely or somewhat likely that this mode of transmission is possible (see Table 5.2).

OF the NSBA sample, 35% responded at the very unlikely level, 27% at the definitely not possible level. Only 12% believed that it is either very likely or somewhat likely (Dawson & Hardy, 1989). Both samples were comparable at the very unlikely response level.

11. Being bitten by mosquitos or other insects.

Approximately 20% of the BFPH sample believed that it is very unlikely that AIDS is transmitted when bitten by mosquitos or other insects. About 11.6% responded at the definitely not possible level. A large proportion, 41.1% believed that it is either very likely or somewhat likely (see Table 5-2).

When combined with the 17.8% who did not know, one can conclude that a strong level of misconception exist about this mode of transmission.

The NSBA sample projected a 20% response rate at the very unlikely level. About 16% responded at the definitely not possible level. At the very likely and somewhat likely response levels, a 31% response rate is demonstrated. As with the BFPH sample, a high percentage, 25%, responded at the don't know level (Dawson & Hardy, 1989).

TABLE- 5-2

COMPARISONS: MODES OF AIDS TRANSMISSION				
UNLIKELY/DEF.NOT ITEM:	LIKELY\SOMEWHAT LIKELY			
	BFPH	NSBA	BFPH	NSBA
	<u>PERCENT OF SAMPLE</u>			
1.Living near a home or hospital for AIDS Patients.	20.9%	9%	59.7%	70%
2.Working near someone with AIDS.	28.7	15	49.7	59
3.Eating in a restaurant where the cook has the AIDS virus.	38.0	32	31.1	38
4.Kissing-with exchange of saliva-a person who has the AIDS virus.	64.3	54	17.1	20
5.Shaking hands, touching or kissing on the cheek someone who has the AIDS virus.	17.8	13	62.8	62
6.Sharing plates, forks, or with someone who has the AIDS virus.	31.8	33	41.8	40
7.Using public toilets	31.8	25	38.7	48
8.Sharing needles for drug use with someone who has the AIDS virus.	97.7	95	1.6	02
9.Being coughed or sneezed on by someone who has the AIDS virus.	40.3	32	38.0	37
10.Attending school with a child who has the AIDS virus.	17.8	12	55.8	62
11.Being bitten by mosquitos or other insects.	41.1	31	31.8	36
LEGEND:				
1.BFPH= BLACK FAMILIES IN PUBLIC HOUSING				
2.NSBA= NATIONAL SAMPLE OF BLACK AMERICANS				

SUMMARY

A lower percentage of black families in the public housing sample were knowledgeable on seven (67%) of the

eleven items designed to measure AIDS knowledge of transmission. Thus, the hypothesis is supported. Tests of statistical significance were not possible due to the nature of the data presented by the National Center for Health Statistics.

Within the NSBA sample, a considerable degree of variability in the responses to certain items, can be accounted for by the differences in age. Responses within the NSBA sample varied with age, those persons over the age of 55 scored less well. Within the BFPH sample, there were too few subjects (20) beyond the age of 55 to reflect this pattern.

About 35.8% of the NSBA sample did not complete high school, 25.5% had more than twelve years of education. Thirty-one percent of the BFPH sample did not complete high school, 26.4% had more than twelve years of education. The two samples were comparable, thus the difference is probably not due to education.

Because a public housing project is a well defined community, residents are probably subject to greater influence by inaccurate knowledge that is communicated among the residents.

Misconceptions about how AIDS is transmitted exist within the sample of black families residing in public housing. Implied here, is a need for intervention. The intervention should seek to reduce the level of

misconceptions. Well informed families can provide accurate knowledge to their teenage children.

KNOWLEDGE ABOUT AIDS PREVENTION AND COMPARISONS WITH
NATIONAL SAMPLE

Knowledge about how to prevent AIDS was obtained through responses on a five item scale. Correct responses were determined by the National Center for Health Statistics and is based on the current state of knowledge.

The following frequency distribution illustrates the responses by the household heads of 129 black families residing in public housing (hereafter referred to as the BFPH sample).

TABLE 5-3

RESPONSES TO AIDS PREVENTION SCALE

NUMBER OF CORRECT ITEMS	N	PERCENT	CUMULATIVE PERCENT
.00	10	7.8	7.8
1.00	25	19.4	27.1
2.00	40	31.0	58.1
3.00	40	31.0	89.1
4.00	14	10.9	100.0
Totals		129	100.0

The mean number of correct responses stand at 2.17 (SD=1.10) (median=2; mode=2).

Almost 8% of the sample did not provide any correct responses. No one was able to provide correct responses to all items. Only ten percent were able to respond correctly to four items (see Table 5-3).

A closer analysis of individual items will identify areas for possible intervention. The following responses were noted when asked how effective is:

1. Using a diaphragm.

Of the BFPH sample, 40.3% thought that using a diaphragm is not at all effective in preventing AIDS. Approximately 18.6% did not know how effective and 15.6 percent did not know the method. In addition, 8.5% believed the diaphragm to be very effective and 17.1% thought it to be someone effective. This combination indicates there exist much confusion about the effectiveness of the diaphragm for preventing AIDS within this sample.

Current and future diaphragm users within this sample are at risk of contracting AIDS. Additional knowledge is warranted.

In the NSBA, 47% believed that the diaphragm is not at all effective in preventing AIDS. About 12% of the sample believed that the diaphragm is somewhat effective and only five percent believed it to be very effective. Twenty-four percent did not know how effective, 11% did not know the method (Dawson & Hardy, 1989).

A greater proportion of the NSBA sample (47%) was aware that the diaphragm is not at all effective for preventing AIDS when compared to the BFPH sample (40%) (see Table 5-4).

2.Using a condom.

Of the BFPH sample 39.5% believed that the condom is a very effective means of preventing AIDS. An additional 43.4 percent believed that the condom is somewhat effective. Combined, the 4.7% who did not know the method and the 4.7% who did not know how effective, demonstrates a potential risk of AIDS. Some 7.8 percent believed that the condom is not at all effective for preventing AIDS.

In the NSBA sample, 29% believed that the condom is a very effective method of preventing AIDS. Another 47% believed that the condom is somewhat effective. Only eight percent believed that the condom is not at all effective. About 13% did not know how effective, 4% did not know the method.

Blacks in the BFPH sample (39.5%) were more aware that the condom is a very effective method of preventing AIDS than members of the NSBA (29%)(see Table 5-4).

3.Using a spermicidal jelly, form, or cream.

Only 16.3% of the BFPH sample believed that spermicidal jelly, cream, or form is a somewhat effective method of

preventing AIDS, 6.2% believed it to be very effective. A substantial proportion, 37.2%, believed the this method is not at all effective. About 23.3% did not know how effective, 16.3% did not know method.

In the NSBA black sample, only twelve percent believed that spermicidal jelly, form, or cream is somewhat effective as a method of preventing AIDS. Only three percent believed that the method is very effective. Forty-eight percent believed that the method is not at all effective. Moreover, 27% did not know how effective, ten percent did not know method (Dawson & Hardy, 1989).

A higher proportion of the BFPH sample (16.3%) believed that spermicidal jelly, form, or cream is a somewhat effective method of preventing AIDS, when compared with the NSBA sample (12%). A higher proportion also did not know method, 16.3 versus 10%. A higher proportion of the NSBA sample (48%) believed that the method is not at all effective, when compared with the BFPH sample (37.2%) (see Table-5-4).

4. Having a vasectomy.

A large proportion (44.2%) of the BFPH sample correctly, recognized that a vasectomy is not at all effective as a method of preventing AIDS. Some seven percent of the sample believed that the method is very effective, 8.5% believed it to be somewhat effective.

Almost 21% did not know the method and 18.6% did not know how effective. Some level of risk of AIDS exist when one does not know how effective a particular method might be.

Both the NSBA sample and the BFPH sample compare favorably in their inability to know how effective the method is in preventing AIDS, 19 and 18.6% respectively. A greater proportion of the respondents in the NSBA sample (70%) believed that the method is not at all effective in preventing AIDS, compared to 44.2% of the BFPH sample. Almost 21% of the BFPH sample did not know method, compared to seven percent of the NSBA sample.

In the NSBA sample, 57% believed that a vasectomy is not at all effective as a method of preventing AIDS. Only two percent believe the method to be very effective, and four percent, somewhat effective. However, 24% did not know how effective, 13% did not know method (Dawson & Hardy, 1989).

A higher percentage of blacks in the BFPH sample (20.9%) did not know the vasectomy method. A higher proportion of blacks in the NSBA sample were aware that the vasectomy is not at all effective (57%), compared to the BFPH sample (44.2%) (see Table 5-4).

5. Two people who do not have the AIDS virus having sex only with each other.

A large proportion (64.3%) of the BFPH sample believed that an exclusive relationship is a very effective method of preventing AIDS. In addition, 11.6% believed the method to be somewhat effective. Only 12.4% of the BFPH sample believed that the method is not at all effective. A low of seven percent did not know how effective, 4.7% claimed that they did not know the method.

In the NSBA sample (71%) believed that the method is very effective in preventing AIDS. In addition, 13% believed the method to be somewhat effective. Only five percent believed that the method is not at all effective. A low of nine percent did not know how effective, three percent did not know method.

TABLE 5-4

 COMPARISONS: MODES OF AIDS PREVENTION RESPONSES

	EFFECTIVE/SOMEWHAT EFF.		NOT	
EFFECTIVE				
	<u>PERCENT OF SAMPLE</u>			
ITEM:	<u>BFPH</u>	<u>NSBA</u>	<u>BFPH</u>	<u>NSBA</u>
1.Using a diaphragm	25.6	17	40.3	47
2.Using a condom	82.9	76	7.8	08
3.Using a spermicidal jelly, form, or cream	22.5	15	37.2	48
4.Having a vasectomy	15.5	06	44.2	57
5.Monogamous relat- ionships	76.0	84	12.4	05

LEGEND:

1.BFPH= BLACK FAMILIES IN PUBLIC HOUSING

2.NSBA= NATIONAL SAMPLE OF BLACK AMERICANS

A high proportion of both samples believed that an exclusive relationship is a very effective method of preventing AIDS. The sample of black families in public housing projected higher levels of misconceptions about how to prevent AIDS with respect to all methods: use of condoms, a diaphragm, having a vasectomy, the use of spermicidal jelly or cream and having a monogamous relationship.

This difference may be due to the fact that the public housing sample represents a geographically specific community rather than a dispersed national sample. Within tightly defined communities, misconceptions can be easily transmitted and reinforced.

SUMMARY: KNOWLEDGE OF AIDS TRANSMISSION AND PREVENTION

H₁ Black parents from inner-city housing projects obtain lower percentage of correct responses to the knowledge of AIDS transmission and prevention scales than blacks in the general population.

Levels of AIDS knowledge were determined through the number of misconceptions about how AIDS is transmitted and prevented. Black parents in Public housing demonstrated misconceptions on 7 (67%) of 11 items related to transmission and 5 (100%) of 5 items related to prevention,

as compared with the national sample of black Americans (see Tables 5-3,5-4). Thus, the hypothesis is supported.

Knowledge gaps were demonstrated in all three areas of AIDS knowledge. The more profound deficits are in the areas of transmission and prevention. Deficits in both knowledge of transmission and prevention can result in continued engagement in high risk behaviors throughout the family system. Knowledge of prevention and transmission represent a very specific knowledge base where systematic knowledge is needed. Formal or semi-formal settings can best provide this type of knowledge. Public housing parents may have had less access to such settings. In addition, inner-city public housing residents live in an environment where misconceptions can be readily reinforced.

A note of caution is in order with respect to this finding. The two population samples were tested at differential points in time. History may impact upon performance. The BFPH sample should be better informed than the NSBA sample because of the time differential in testing. But also, we would expect them to be less informed because of low SES and the environment of the housing project.

Because of the noted deficits, intervention is needed. The primary goal of such intervention is to enhance the level of knowledge on the part of parents. Parents are then positioned to provide accurate knowledge to their teenage children.

CHAPTER V1

FINDINGS:AIDS KNOWLEDGE AND SPECIFIED DEMOGRAPHIC VARIABLES

The chapter evaluated the relationship between AIDS knowledge and specified demographic variables. AIDS knowledge is distributed into three distinct areas, general knowledge, transmission, and prevention. Two areas, AIDS transmission and prevention will be evaluated using the appropriate statistical instrument. The following relationships are evaluated:

H₂ Female household heads will demonstrate higher levels of Knowledge of AIDS transmission and prevention than male heads.

There are 48 men and 81 women participants in this study.

The T-Test revealed no significant relationship between gender and level of AIDS knowledge of transmission (T-Value = .34, DF=127, $P < .734$).

The T-Test revealed no significant relationship between gender and level of knowledge of AIDS prevention (T-Value = .40, DF = 127, $p < .690$).

DISCUSSION

There are no significant differences between the level of knowledge of AIDS transmission and prevention for men and women. Thus, the hypothesis is not supported.

Parents who perceived that their children are at risk will act to protect them in various ways. Since there is no cure for AIDS at present, prevention through education and behavior change are the desired strategies. Thus, it is expected that all concerned parents will acquire the available knowledge perceived to be significant for prevention. Fifty-one point two percent of the sample professed to have some knowledge of AIDS, 16.3% professed to have a lot of knowledge. According to findings reported in chapter 5, respondents exhibited lower levels of AIDS knowledge of transmission and prevention when compared with a national sample of blacks.

Women rather than men, become involved in discussing sex with their children. Women have traditionally taken on the role as nurturer and as such may act to protect their children. Thus, one would expect women to possess relevant knowledge for these roles.

Perhaps, both men and women within this sample have had equal access to available AIDS knowledge and share similar perceptions.

H₃. Knowledge of AIDS transmission and prevention will vary with education.

Pearson's R revealed that knowledge of AIDS transmission has only a very small correlation with education ($R = .0685$, $P > .05$).

Pearson's R also revealed that knowledge of AIDS prevention also has but a small correlation with education ($R = .1111$, $P > .05$).

Given small correlations, the hypothesis is not supported.

These findings are not consistent with results presented by a national sample of black Americans. Correct responses to items regarding both knowledge of AIDS transmission and prevention varied with education. Respondents with twelve or more years of education were more successful in providing correct responses (Dawson & Hardy, 1989). It is reasonable to expect knowledge to vary with education.

Within the investigator's sample, the full spectrum of educational levels were represented. Additionally, both samples were similar in the percentages of high school and non-high school graduates. Thus, it is logical to expect similar results.

Because public housing projects have well defined boundaries, there is a greater potential for the reinforcement of existing misconceptions about how AIDS is transmitted and prevented. In fact, respondents in this

sample were found to possess numerous misconceptions about how AIDS is transmitted and prevented (see chapter 5).

If stereotypical views are reinforced within this housing project, a variation based upon differential educational levels will not be demonstrated.

SUMMARY: KNOWLEDGE OF AIDS TRANSMISSION, PREVENTION AND SPECIFIED DEMOGRAPHIC VARIABLES

Statistical tests were conducted to evaluate the relationship between knowledge of AIDS transmission, prevention and specified demographic variables. Compared to General AIDS knowledge, knowledge of AIDS transmission and prevention are limited to specific areas of knowledge. Knowledgeability is in part, a function of one's exposure to these well articulated areas of knowledge.

As indicated above, hypotheses 2 through 3 were not supported. No significant correlations were found to exist between knowledge of AIDS transmission, prevention and gender and education. Apparently, respondents with less than a high school education were as knowledgeable about AIDS prevention and transmission. Perhaps this is reflective of persistent misconceptions that are reinforced within the boundaries of the housing project. However, it is noted that over 80% of the respondents reported having read brochures and pamphlets about AIDS, 58% during the month preceding the interview.

In a national sample of black Americans, knowledge of AIDS transmission and prevention varied with education. Persons with less than 12 years of education were less knowledgeable as reflected on specific items (Dawson and Hardy, 1989).

CHAPTER V11FINDINGS: AIDS KNOWLEDGE AND COGNITIVE-BEHAVIORAL SKILLS

The purpose of this chapter is to test four hypotheses, three concerning the relationship between general AIDS knowledge, knowledge of AIDS transmission and knowledge of AIDS prevention and skills of perceived problem-solving ability, assertiveness and self-reinforcement. The fourth hypothesis examines the relationship between perceived comfort in discussing AIDS and sex with children and the cognitive-behavioral skills of perceived problem-solving ability, assertiveness and self-reinforcement. The sample's performance on each of the skills scales will be presented. The findings relative to each hypothesis will be examined separately.

H₄ General AIDS knowledge will vary with the cognitive-behavioral skills of perceived problem-solving ability, assertiveness and frequency of self-reinforcement.

H₅ Knowledge of AIDS transmission will vary with the cognitive-behavioral skills of perceived-problem solving, assertiveness and frequency of self-reinforcement.

H₆ Knowledge of AIDS prevention will vary with the cognitive-behavioral skills of perceived problem-

solving, assertiveness and frequency of self-reinforcement.

H₇ Perceived comfort in discussing AIDS and sex with children will vary with perceived problem-solving ability, assertiveness and frequency of self-reinforcement.

An essential assumption upon which this research rests is that accurate AIDS knowledge and the skills of perceived problem-solving ability, self-reinforcement, and assertiveness are requisites to the communication of AIDS prevention messages.

PERCEIVED PROBLEM-SOLVING ABILITY

The problem-solving scale contains three sub-scales. They are 1).problem-solving confidence (F-1), 2). approach-avoidance (F-2), and 3).personal control (F-3). Overall perceived problem-solving ability is referred to as (F-4). See table 7-1 for an illustration of how the sample responded.

Within the sample, scores for overall problem solving ability ranged from 43 to 125. The mean score for the sample is 75.062 (S.D.=17.862)(mode=52;median=76.000). Lower scores indicate greater perceived problem-solving abilities (Heppner & Petersen, 1982). See table- 7-1.

Table-7-1

SAMPLE RESPONSES ON PROBLEM-SOLVING SCALES				
	MEAN	STANDARD DEVIATION	MODE	MEDIAN
1.CONFIDENCE (F-1)	27.710	9.594	30.000	28.000
2.APPROACH- AVOIDANCE (F-2)	43.966	9.940	48.000	44.000
3.PERSONAL- CONTROL (F-3)	16.120	6.132	17.000	17.000
4.OVERALL- ABILITY (F-4)	75.062	17.862	52.000	76.000

FREQUENCY OF SELF-REINFORCEMENT SCALE

Scores ranged from 43 to 90. Higher scores represent greater use of self-reinforcement skills (Heiby, 1983). The mean score for the sample is 63.122 (S.D.= 10.5); (median=63;mode=60), (See table-7-2).

TABLE-7-2

SAMPLE RESPONSES TO SELF-REINFORCEMENT SCALE				
	MEAN	STANDARD DEVIATION	MODE	MEDIAN
SELF-REINFORCEMENT	63.122	10.500	60.000	63.000

SIMPLE RATHUS ASSERTIVENESS SCHEDULE

Scores for the sample ranged from 69 to 160. The mean score is 120.9(S.D. = 18.0) (mode= 123;median=122.5). Higher

scores reflect greater assertiveness (McCormick, 1984), (see Table -7-3).

TABLE- 7-3

SAMPLE RESPONSES TO ASSERTIVENESS SCALE				
	MEAN	STANDARD DEVIATION	MODE	MEDIAN
ASSERTIVENESS	120.945	18.066	123.000	122.500

GENERAL AIDS KNOWLEDGE AND SKILLS

1.Using Pearson's R, general AIDS knowledge does not correlate with perceived problem-solving ability, in any meaningful way.

Factor-1 (problem-solving confidence): (R = $-.2206$, P > .05)

Factor-2 (approach-avoidance): (R = $-.0972$, P > .05)

Factor-3 (personal control): (R = $-.0710$, P > .05)

Factor-4 (overall problem-solving): (R = $-.1601$, P > .05)

2.Using Pearson's R, general AIDS knowledge is correlated with assertiveness (R = $.2550$, P < 0.05).

3.Using Pearson's R, general AIDS knowledge is not correlated with frequency of self-reinforcement in any meaningful way (R = $.1622$, P > .05).

The hypothesis (H₄) is partially supported, general AIDS knowledge does not correlate with perceived problem-solving ability or frequency of self-reinforcement. However, there is a positive relationship to assertiveness. As assertiveness increases, general AIDS knowledge increases. Assertiveness is a reflection of the individual's ability and willingness to approach a challenge and is one possible skill in a task completion process. It is possible to be assertive and not possess perceived skills in problem-solving. Over long time frames, assertiveness may decrease when perceived problem-solving ability does not, in reality, lead to actual problem-solving.

Individuals who self-appraised as effective problem-solvers have been found to be more motivated, persistent, less avoidant and usually understands problems relatively well (Heppner, et al., 1982).

The absence of a relationship between general AIDS knowledge and problem-solving skills may be reflective of the sample's response to the problem-solving scale. The sample projected a moderately high level of perceived problem-solving ability (mean= 75; SD=17.8; median =76; Range= 43-125). At the same time, misconceptions about AIDS were noted in many areas.

KNOWLEDGE OF AIDS TRANSMISSION AND SKILLS

1.Using Pearson's R, knowledge of AIDS transmission correlates inversely with both overall perceived problem-solving ability and problem-solving confidence, a component of perceived problem-solving ability. As knowledge of AIDS transmission increases, perceived problem-solving ability decreases, and problem-solving confidence as well.

Factor 1 (problem-solving confidence): ($R = -.3254$, $P < .001$)

Factor 4 (overall problem-solving): ($R = -.3077$, $P < 0.01$)

2.Using Pearson's R, knowledge of AIDS transmission is positively correlated with assertiveness ($R = .2583$, $P < 0.05$). As knowledge of AIDS transmission increases, the level of assertiveness increases.

3.Using Pearson's R, knowledge of AIDS transmission does not correlate meaningfully, with self-reinforcement ($R = .1327$, $P > .05$).

The hypothesis (H_5) is partially supported. Knowledge of AIDS transmission is inversely correlated with overall perceived problem-solving ability and problem-solving confidence, a component of perceived problem-solving ability. Knowledge of AIDS transmission is positively correlated with assertiveness. However, knowledge of AIDS

transmission does not correlate with the frequency of self-reinforcement.

For this sample, problem-solving confidence appears to be the dominant problem solving skill linking overall perceived problem-solving ability with knowledge of AIDS transmission. The inverse relationship between knowledge of AIDS transmission and perceived problem-solving ability is an interesting finding. It is reasonable to expect the level of AIDS knowledge to increase with one's perceived ability to solve problems. Apparently a third factor is influencing this relationship. If one perceives newly acquired knowledge of AIDS as threatening, it is reasonable to expect one's perceived problem-solving ability to decrease.

Assertiveness, often manifested both verbally and behaviorally, can facilitate the acquisition of knowledge from various sources, through a sustained effort. A sustained effort in conjunction with the perception that one has the ability to succeed is a powerful combination.

The respondents manifested a high level of assertiveness (mean = 120.94; SD = 18; median = 122.5). At the same time, the respondents manifested low to moderate use of self-reinforcement skills (mean = 63; SD = 10.5; median = 63). Self-reinforcement is apparently valuable when external support systems are not available. An

evaluation of the nature of the support system was not within the scope of this study.

KNOWLEDGE OF AIDS PREVENTION AND SKILLS

1. Using Pearson's R, knowledge of AIDS prevention does not correlate meaningfully, with problem-solving ($R = -.0993$, $P > .05$), frequency of self-reinforcement ($R = -.0335$, $P > .05$), or assertiveness ($R = -.2287$, $P > .05$).

The hypothesis (H_6) is not supported. Knowledge of AIDS prevention is not related to perceived problem-solving ability, assertiveness or frequency of self-reinforcement. The sample manifested a lower level of knowledge of AIDS prevention when compared with a national sample. Such may account for the lack of a relationship.

The responses to the AIDS prevention scale may have been too low to reflect a relationship. Almost 8% of the respondents were not able to provide any correct responses. No respondent was able to provide correct responses to all five items.

SUMMARY: AIDS KNOWLEDGE AND SPECIFIED COGNITIVE-BEHAVIORAL SKILLS

Several hypotheses were partially supported. General AIDS knowledge is not meaningfully related to perceived problem-solving ability or the use of self-reinforcement skills, for this sample. But, general knowledge of AIDS is

positively related to the use of assertiveness. General knowledge of AIDS is less specific than knowledge of AIDS transmission and prevention, therefore is not focused toward a particular end. This pattern may have less impact upon the reader. Knowledge of AIDS transmission and prevention are action oriented and directs the receiver toward very specific ends.

General AIDS knowledge increases with assertiveness. The linkage suggests that the subjects are likely to actively confront certain AIDS related challenges. It is reasonable to expect that subjects will demonstrate differential use of assertiveness skills.

Knowledge of AIDS transmission is inversely correlated with both overall perceived problem-solving ability, and problem-solving confidence. Therefore, as knowledge of AIDS transmission increases, perceived problem-solving ability along with problem-solving confidence decreases.

This relationship suggests that perceived problem-solving confidence and overall perceived problem-solving ability are skills that are not of great significance in promoting the acquisition of AIDS knowledge, for the subjects and cannot be used as a resource in our efforts to convey AIDS prevention messages within black inner-city families. Caution is warranted here, as correlation does not imply cause and effect. Extraneous variables may account for the inverse relationship.

Knowledge about how AIDS is transmitted can be perceived as a threat. Under such conditions, individuals may not look positively at their perceived ability to solve problems. Knowledge of AIDS transmission is correlated with assertiveness. Therefore, as knowledge of AIDS transmission increases, assertiveness increases. Assuming that knowledge of transmission alerts one to his potential for getting AIDS, a mental linkage between the two variables may be made by individuals. Knowledge of AIDS transmission and assertiveness are interactive.

Finally, Knowledge of AIDS prevention is not meaningfully correlated with either of the cognitive-behavioral skills. This response set may reflect the fact that some subjects were not familiar with certain prevention strategies. For example, 21% of the sample were not familiar with a vasectomy. 16%, the use of spermicidal jelly, 15%, the use of a diaphragm and 5%, the use of condoms.

What emerges here are possible factors that ought to be considered in developing skills building programs, that are directed toward AIDS prevention at the family level.

Assertiveness correlates, meaningfully, with both general AIDS knowledge and knowledge of transmission. Perceived problem-solving skills is potentially useful, however, the inverse correlation has implications that are different than those for assertiveness. Both of these

skills are candidates for further study of potential use, in family-based AIDS prevention efforts.

Correlation does not necessarily imply causation.

Clearly, more definitive research is needed in order to establish linear relationships. However, ethical issues related to manipulation and control of independent variables must be considered.

PERCEIVED COMFORT IN DISCUSSING AIDS AND SEX WITH CHILDREN AND SKILLS

H7 Perceived comfort in discussing AIDS and sex with children will vary with perceived problem-solving ability, assertiveness and frequency of self-reinforcement.

The relationship between perceived comfort in discussing AIDS and sex with children was examined. Self-efficacy should be interactive with assertiveness, problem-solving and self-reinforcement. Of the parents studied, 91.5% either strongly or moderately agreed that they felt comfortable discussing AIDS and sex with their children.

The relationship with each of the skills will be examined, then discussed.

PERCEIVED PROBLEM-SOLVING AND COMFORT

Pearson's R revealed a positive correlation between felt comfort level and overall perceived problem-solving ability ($R = .2497$, $P < 0.05$) as well as approach-avoidance, a component of perceived problem-solving ability ($R = .3711$, $P < 0.01$). No meaningful correlation exists between felt comfort and personal control ($R = .0694$, $P > .05$) or problem-solving confidence ($R = .1627$, $P > .05$).

Subjects who expressed felt comfort in discussing AIDS and sex with their children demonstrated some perceived problem-solving ability. As perceived comfort level increases, perceived problem-solving ability increases. This pattern is consistent with the finding which links self-efficacy with levels of performance accomplishments (Bandura, 1982).

The negative correlation between problem-solving confidence and frequency of self-reinforcement is puzzling. Problem-solving confidence and self-reinforcement should be mutually reinforcing. Since, self-reinforcement is frequently used when an external support system is unavailable, it is not unreasonable to observe an inverse relationship.

ASSERTIVENESS AND PERCEIVED COMFORT

Pearson's R revealed that there is no meaningful correlation between assertiveness and perceived comfort in discussing AIDS and sex with children ($R = -.0694$, $P > .05$).

Assertiveness is a useful skill for approaching events and situation that are perceived as threatening. Taboo areas such as AIDS and sex may pose a threat to some individuals. Therefore it is reasonable to expect some members of the sample to experience such a threat. A majority of the parents (79.8%) indicated that they had discussed AIDS with their children. This finding implies that the respondents are willing to approach their children. Moreover, in our objective measure of assertiveness within the sample, a mean score of (120.9;SD = 18) was attained by the sample. A mean of 120.94 implies a relatively high level of assertiveness. Established norms of (Mean = 94.6;SD = 25.4 for females)(Mean = 99.8;SD = 20.1 for males) were reported (McCormick, 1984). The absence of a relationship between the two can only be explained by factors outside the scope of this study.

FREQUENCY OF SELF-REINFORCEMENT AND COMFORT

Pearson's R revealed that there is no substantial correlation between frequency of self-reinforcement and perceived comfort in discussing AIDS and sex with children ($R = .0179$, $P > 0.05$).

Self-reinforcement is a skill that is useful when no external sources of support are present. Where both external and internal sources of support are available, personal preference can come into play. However, sources of

external support were not explored within this study, thus it is not possible to confirm this theory.

An objective measure of frequency of self-reinforcement showed a mean score of 63 ($SD = 10.5$). Combined with the fact that respondents report that they feel comfortable (91.5%), one would expect a relationship to exist. Felt comfort in discussing AIDS and sex with children and the use of self reinforcement should be mutually supportive.

The absence of a relationship may be a function of use of alternative systems of support by the sample.

The hypothesis (H_7) was partially supported. Perceived comfort in discussing AIDS and sex with children is meaningfully correlated with overall perceived problem-solving ability. Perceived comfort in discussing AIDS and sex with children is not meaningfully correlated with assertiveness or self-reinforcement.

CHAPTER-V111IMPLICATIONS AND SUMMARYSUMMARY OF MAJOR FINDINGS

Black families within an inner-city housing project provided a lower percentage of correct responses to knowledge of AIDS transmission and prevention scales than blacks in the general population. This finding is extremely significant in that the sample of black families in public housing provided fewer correct answer than the national sample of blacks who were evaluated in 1988. Since 1988, there has been a proliferation of efforts directed toward communicating AIDS prevention messages.

The response pattern by the public housing sample projected numerous misconceptions about how AIDS is transmitted and prevented. Interventions directed toward eradicating these misconceptions are warranted.

No significant difference was found between the level of AIDS knowledge possessed by both men and women within the sample. Implied here is that men and women within the sample are comparable in both their need for more accurate knowledge about AIDS as well as their potential for transmitting current knowledge to their children.

Generally speaking, women are more involved than men in providing their children with knowledge about sex. This pattern is likely to continue within black families as a significant number of these families are headed by women.

The study also found that general AIDS knowledge is positively correlated with the skill of assertiveness. Assertive behavior can diminish both real and perceived obstacles to effective communications. Given, that AIDS and sex are tabooed areas, assertiveness is a valuable skill to possess. However, noted is the fact that a single skill alone is not always effective. Assertiveness can best be perceived as a resource for selective use.

Knowledge of AIDS transmission is inversely correlated with perceived problem-solving ability. A perceived ability to solve problems is likely to increase motivation and facilitate the expending of time and energy in seeking solutions. The inverse correlation suggests otherwise for this sample.

Having an awareness about how AIDS is transmitted is empowering. One has the potential for improving sexual health and reducing the level of anxiety. One notes that the mere possession of knowledge does not ensure appropriate behavioral responses. Increased awareness is only a first step in the process of changing behaviors. However, the combination of accurate knowledge and a perceived ability to solve problems is a powerful mix. Knowledge of AIDS

transmission is also positively correlated with level of assertiveness. Assertiveness is reflective of the extent to which one is motivated toward desired goals.

It is of interest to note that assertiveness is positively correlated with both general AIDS knowledge and knowledge of transmission.

Finally, the study found that perceived comfort in discussing AIDS and sex with children correlated positively with perceived problem-solving ability. This relationship is significant in that it alerts us to a skill that can serve as a resource for parents.

Felt comfort in discussing AIDS and sex with children is not meaningfully correlated with level of assertiveness or frequency of self-reinforcement.

STRENGTHS OF THIS STUDY

There are several strengths to this study. First, the study evaluated a significant social problem, that of AIDS. In addition, a relevant population group, inner-city black families residing in public housing projects, is the target of my evaluation. Second, several relevant correlations have been suggested by the findings in this study. Skills for potential use in training programs that are designed to assist black families in communicating AIDS prevention messages to their teenage children have been identified.

Relevant skills are perceived problem-solving ability and assertiveness.

Additionally, the study identified AIDS knowledge deficits within the sample. Intervention is needed to enhance the level of AIDS knowledge within this sample. Some possible variables for inclusion in a follow-up study have been identified. Assertiveness and problem solving are two of these variables.

Finally, the study provided a description of how black families residing in high risk neighborhoods are responding to AIDS.

WEAKNESSES

The participants were self-selected and may not be representative of the population within the project. Although informative, findings cannot necessarily be generalized beyond the sample studied.

Rather than measuring the actual behavior within the families, the study relied upon self-reports by the subjects. There are inherent problems with self-reports. First, there is the problem of accuracy in reporting about oneself. Some respondents tend to give favorable reports about themselves. Second, subjects may attempt to respond based upon the perceived wishes of the interviewer.

Because of the "stigma" attached to AIDS, social desirability may have been a significant factor in this

study, despite assurances of confidentiality and attempts to be non-judgmental. The study also explored sexual content and drug usage, both of which are sufficiently threatening to stimulate underreporting (Fowler, 1984).

Cross-sectional designs are limited in that they reflect the respondent's preferences at a particular time. When the researcher is interested in changes over time, longitudinal designs are preferred.

The instruments used to measure the cognitive-behavioral skills possessed by the subjects in this study, may not be valid with this population. Norms were established on college students and other groups. However, few problems were identified during the field testing of the instruments.

The study did not capture actual parent-child dynamics. The perceptions of the parents were the focus of attention. Perceptions are often stable, but could be altered through re-education and new experiences. Actual dynamics could accentuate the behavioral and verbal dynamics of all participants. Thus, areas where intervention could be especially beneficial are identified.

Data collected on subjects in this study were compared to secondary data from a previous study. Statistical tests of significance were not possible because of the limited form of the secondary data. Complete raw data could have facilitated further analyses (Kerlinger, 1973).

Correlation analyses were used extensively within this study. While useful in identifying relationships, factors responsible for these relationships could not be determined (Craft & Askling, 1985).

RECOMMENDATIONS FOR FURTHER STUDY

Findings from this study have significance for several areas of future research. This study should be replicated using a random sample selected from public housing projects throughout New York city. Findings from such a study could inform interventions at the city level. An evaluation of the level of AIDS knowledge possessed by adolescent children should also be included.

Almost 80% of the parents reported having discussed AIDS with their adolescent children. A follow-up study could investigate the nature, extent and frequency of these informational sessions. At the same time the reactions by their adolescent children could be evaluated. Findings from this study could provide relevant knowledge about actual family dynamics associated with communicating AIDS prevention messages.

Nearly 68% of the respondents reported having either some knowledge or a lot of knowledge of AIDS. Future research should attempt to determine whether there is a relationship between perceived knowledge of AIDS and willingness to participate in an AIDS intervention program.

Findings from this study may provide data regarding possible barriers to involvement in interventive efforts.

To what extent is the level of AIDS knowledge possessed by adolescent children dependent upon the knowledge of AIDS possessed by parents? An understanding of this phenomenon could accentuate the relative importance of providing parents with accurate knowledge of AIDS.

Over 50% of the respondents reported that they personally knew someone with AIDS, 31% indicated they knew the person with AIDS very well. An understanding of the relationship between personal knowledge of someone with AIDS and perceived risks of AIDS could inform us about and additional factor in AIDS intervention.

Knowledge of AIDS transmission was inversely correlated with overall perceived problem-solving ability and problem-solving confidence. This is an unexpected relationship. It is reasonable to expect perceived problem-solving ability and problem-solving confidence to increase as knowledge of AIDS transmission increases. Future research may provide us with an understanding of the factors responsible for the inverse relationship. The responsible factors may be relevant for structuring an intervention program.

A second phase of research should involve the field testing of possible interventions under controlled conditions. Suggested components for the intervention are problem-solving and assertiveness skills, knowledge of how

AIDS is transmitted as well as prevented. Findings from this study could inform future research about variables that are potentially significant. Thus a refined intervention is the ultimate outcome.

IMPLICATIONS FOR PRACTICE

Effective social work practice is built upon sound knowledge, skills, and methods. Providing inner-city black families with the knowledge and skills needed to prevent the transmission of AIDS among their family members is a significant practice goal.

Based upon the findings from this study, social work practitioners must be prepared to provide parents with relevant skills or trained community residents/organizations to provide residents with relevant skills. The findings further suggest that the family represents one possible point of intervention for AIDS prevention among teenagers.

The findings from this study, limited generalizability duly noted, can serve as a beginning point and stimulus for further study. Survey findings suggest some of the possible dimensions of intervention programs designed to arm inner-city black families with the ability to communicate AIDS prevention messages to its members. A possible next step is to develop an intervention program that includes both knowledge of AIDS transmission, prevention, perceived problem-solving and assertiveness. Social work practitioners, including community organizers are trained to

implement intervention programs within the context of a caring atmosphere.

Social work is practiced at several levels, including policy, planning, administration and direct practice, with a variety of client systems. However, findings from this study have implications primarily for policy and practice, particularly family and community practice.

Absent a cure, prevention is the preferred strategy for eradication and control. Policy makers in conjunction with administrators, must decide where and how to distribute the limited dollars available for AIDS prevention. New policies should begin to emphasize the family as a primary point of intervention. The findings from this study, within limits, provide some beginning insights into the relevant skills and knowledge needed by inner-city black families for AIDS prevention purposes.

The findings also suggest that AIDS prevention programs designed for use with black inner-city families should:

1. Be prepared to provide black parents with accurate knowledge about how AIDS is transmitted and prevented.
2. Recognize that assertiveness skills may be useful in helping some parents to successfully engage obstacles that might impede their desire to discuss AIDS with their teenage children.
3. Recognize that parents who feel comfortable in discussing AIDS and sex with their teenage children are likely to

perceive themselves as having the ability to solve problems.

4. View men and women as having similar needs and abilities relative to accurate AIDS knowledge.

5. Recognize that possessing knowledge about how AIDS is transmitted does not necessarily mean that the parents perceive that they have the ability to solve problems.

Direct service practitioners are provided some insight into areas to be assessed during their contacts with both individuals and families. Accurate assessments will permit practitioners to refine existing intervention strategies as well as develop new ones. Direct intervention with individuals, families and groups is warranted in the AIDS prevention efforts. The assessment will direct the practitioner toward the most appropriate point of intervention, given the problem situation.

Over the past ten years, self-help groups have played an important role in the delivery of services to people in need. Self-help groups are often leaderless and consist of members sharing common needs. Heavy reliance upon the experiential knowledge of the participants is essential to the success of the group. The need for AIDS knowledge could be met within the context of community-based groups. Social workers could offer their expertise in formulating or stimulating the development of self-help groups. Existing social welfare agencies within central Harlem may provide needed space.

A significant practice goal is to empower clients.

Social work interventions that are geared toward providing parents with the knowledge and skills needed to transmit AIDS prevention messages to their children have, in effect, empowered them. Parents are in a position to positively impact upon the adaptive behaviors of their children.

Current practice strategies are informed by multi-dimensional assessments, where the full range of input into a problem situation is evaluated. Practitioners must then be creative enough to structure their family-based interventions upon the needs of clients rather than solely upon methodological considerations. This approach is likely to be invaluable in work with black residents of high risk neighborhoods. Findings from this study indicate that blacks in the general population have needs that are different from those of blacks in public housing projects.

Finally, community level intervention has long been the arena of community organizers and community development specialists. Their skills are invaluable in mobilizing the entire community around the problem of AIDS. Findings from this study could serve to inform their interventions. Through educational and mobilizing efforts, the community is made aware of useful strategies to prevent AIDS. More importantly, the community is assisted to function independently over time.

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APPENDICES

APPENDIX A

INTERVIEW PROTOCOL

1. Extend a greeting and thank the prospective subject for his/her interest in the study.
2. Provide the potential subject with a brief explanation of the goals of the study.
 - A. Assess the participant's knowledge of AIDS.
 - B. Learn whether parents are communicating with their teenage children about AIDS.
3. Ask the following screening questions.
 - A. Do you reside in this housing project?
 - B. Do you have/ are you the guardian of teenage children between the ages of thirteen and eighteen?
4. If no to either question, thank the prospective subject and indicate that we cannot use him/her in this study.
5. If yes, prepare to administer the questionnaire.
 - A. Advise subject of our commitment to keep all answers confidential.
 - B. Advise subject that he/she may refuse to answer any question perceived as unworthy of a response.
 - C. Administer the AIDS Knowledge and Attitude questionnaire.

ALLOW A TEN MINUTE BREAK

D. Administer the Problem-Solving Scale.

ALLOW A TEN MINUTE BREAK

E. Administer the Simple Rathus Assertiveness Scale.

ALLOW A TEN MINUTE BREAK

F. Administer the Frequency of Self-Reinforcement Scale.

6. Express our appreciation to the subject.

A. Ask subject to sign the 'Consent to Participate'.

B. Give the subject the \$10.00 fee and obtain a signature on the official receipt.

APPENDIX B

AIDS KNOWLEDGE AND ATTITUDE: ADULTS

Date: _____

Test Time: _____

Name: _____

Address: _____

Telephone Number: _____DEMOGRAPHIC INFORMATION

1. Subject I D Number _____

2. Name of

Interviewer _____

3. Location of Interview _____

4. Mode of the Interview:

1). Self-Administered _____

- 2). Face-to-Face_____
- 3). Group_____
- 4). Other_____

5. Gender Of Subject:

- 1). Male_____
- 2). Female_____

6. Test Time:

- 1). Pretest_____
- 2). Posttest_____
- 3). Follow-Up_____

AGE, ETHNICITY, PLACE OF BIRTH, LEVEL OF EDUCATION, INCOME

7. What is your age?:_____

8. What ethnic group do you consider yourself?:

- 1). Black (Afro-American)_____
- 2). Haitian_____
- 3). Jamaican_____
- 4). Bahamian_____
- 5). West Indian_____
- 6). Other (Specify)_____

9. In what country were you born?

Place of Birth: _____

10. What is the highest level of education you have completed?

- 1). None _____
- 2). Grade School _____
- 3). Some High School _____
- 4). Graduated High School _____
- 5). GED _____
- 6). Some College _____
- 7). Graduated College _____

11. Do you have vocational training?

- 1). No _____
- 2). Yes _____

(Specify) _____

12. Do you receive income from any of the following sources?

- 1). Unemployment Benefits _____
- 2). Disability Benefits _____
- 3). Welfare, Food Stamps or AFDC _____
- 4). Other _____

(Specify) _____

13. Approximately, What is your bi-weekly family take-home income? \$ _____

14. Before taxes, approximately how much income did your family received over the past year?

\$ _____

15. What is your current marital status (Check One)?

1) .Single (Never Married) _____

2) .Married _____

3) .Separated _____

4) .Divorced _____

5) .Widowed _____

6) .Living with significant other _____

7) .Other (Specify) _____

16. How many people live in your household including you?

Number: _____

17. How are they related to you? Starting with the oldest, state their relationship and age.

Relationship	Age
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

18. How many siblings do you have?

Number: _____

THESE QUESTIONS ARE TO DETERMINE WHAT PEOPLE KNOW ABOUT
AIDS.

1. In the past month, have you--

a. Seen any Public Service Announcements about AIDS on television?

___ Yes ___ No ___ Don't Know

If yes, tell me about one.

b. Heard any Public Service Announcements about AIDS on radio?

___ Yes ___ No ___ Don't Know

2. Were any of those Public Service Announcements called "America Responds to AIDS"?

___ Yes ___ No ___ Don't Know

3. In the past month, have you read any brochures or pamphlets about AIDS? Do not include articles in magazines or newspapers.

___ Yes ___ No ___ Don't Know

4. Have you ever read any brochures or pamphlets about AIDS?

Again, do not include articles in magazine or newspapers.

___ Yes ___ No ___ Don't Know

5. Where did you get the pamphlet or brochures? (Mark all that apply)

☐ Clinic other than work clinic

☐ Doctor's Office/HMO

☐ Drug Store

☐ Public Health Department

☐ Received it in the mail without asking for it

☐ Red Cross/with Red Cross blood donation

☐ With other blood donation

☐ School

☐ Sent/Phoned for it myself, requested it

☐ "The Government"-federal, state or local

☐ Work, other than clinic or nurse

☐ Work, nurse or clinic

☐ Other (Specify) _____

6. The government has mailed a brochure with basic information about AIDS to each household in the country. [The brochure is 8 1/2 by 11 inches, white and blue and black printing, and has a picture of Dr. C. Everett Koop, the Surgeon General of the United States on the cover, with the title, "Understanding AIDS" printed on the top.]

Was this brochure received at this household?

☐ Yes

☐ NO

☐ Don't Know

7. How much of the brochure did you read; would you say all or almost all of it, about half, less than half, or none of it.

- ☐ All/Almost all
☐ About half
☐ Less than half
☐ None
☐ Don't Know

8. When you read it, did you read it carefully or did you just skim through it?

- ☐ Read carefully
☐ Skimmed through it
☐ Other (Specify) _____

9. Did the brochure give you any new information or answer any questions you had about AIDS.

- ☐ Yes ☐ No ☐ Don't Know

10. Did you discuss the brochure with anyone else in your family? If yes, whom?

- ☐ Yes ☐ No ☐ Don't Know

11. Do you have any children aged 13 through 18?

☐ Yes☐ No

12. How many do you have? _____

13. Did [this child/any of your children aged 13 through 18]
read the brochure?

☐ Yes☐ No☐ Don't Know

If yes,

whom? _____

14. Was the brochure discussed with [this child/ any of your
children aged 13 through 18]?

☐ Yes☐ No☐ Don't Know

15. Have you ever discussed AIDS with [this child/any of your
children aged 13 through 18]?

☐ Yes☐ No

If yes,

whom? _____

16. [Has this child/Have any or all of your children aged 13
through 18] had instruction at school about AIDS?

☐ Yes☐ No☐ Don't Know

17. How much would you say you know about AIDS?

☐ A lot☐ Some☐ A little☐ or Nothing

18. To the best of your knowledge, is there a difference
between having the AIDS virus and having the disease AIDS?

☐ Yes ☐ No ☐ Don't Know

19. After I read each statement, tell me whether you think
the statement is DEFINITELY TRUE, PROBABLY TRUE, PROBABLY
FALSE, DEFINITELY FALSE, OR YOU DON'T KNOW if it is
TRUE OR FALSE.

a. AIDS can reduce the body's natural protection against
disease.

☐ Definitely True ☐ Probably True ☐ Probably
False ☐ Definitely False ☐ Don't Know

b. AIDS is especially common in older people.

☐ Definitely True ☐ Probably True ☐ Probably
False ☐ Definitely False ☐ Don't Know

c. AIDS can damage the brain.

☐ Definitely True ☐ Probably True ☐ Probably
False ☐ Definitely False ☐ Don't Know

d. AIDS usually leads to heart disease.

☐ Definitely True ☐ Probably True ☐ Probably
False

☐ Definitely False ☐ Don't Know

e. AIDS is an infectious disease caused by a virus.

☐ Definitely True ☐ Probably True ☐ Probably

False

☐ Definitely False ☐ Don't Know

f. Teenager cannot get AIDS.

☐ Definitely True ☐ Probably True ☐ Probably

False

☐ Definitely False ☐ Don't Know

g. AIDS leads to death.

☐ Definitely True ☐ Probably True ☐ Probably

False

☐ Definitely False ☐ Don't Know

h. A person can be infected with the AIDS virus and not have the disease.

☐ Definitely True ☐ Probably True ☐ Probably

False

☐ Definitely False ☐ Don't Know

i. Looking at a person is enough to tell if he or she has the AIDS virus.

☐ Definitely True ☐ Probably True ☐ Probably

False

☐ Definitely False ☐ Don't Know

j. Any person with the AIDS virus can pass it on to someone else through sexual intercourse.

☐ Definitely True ☐ Probably True ☐ Probably

False

☐ Definitely False ☐ Don't Know

k. A person who has the AIDS virus can look and feel well and healthy.

☐ Definitely True ☐ Probably True ☐ Probably

False

☐ Definitely False ☐ Don't Know

l. A pregnant woman who has the AIDS virus can give the AIDS virus to her baby.

☐ Definitely True ☐ Probably True ☐ Probably

False

☐ Definitely False ☐ Don't Know

m. There is a vaccine available to the public that protects a person from getting the AIDS virus.

☐ Definitely True ☐ Probably True ☐ Probably

False

☐ Definitely False ☐ Don't Know

n. There is no cure for AIDS at present.

☐ Definitely True ☐ Probably True ☐ Probably
False

☐ Definitely False ☐ Don't Know

20. After I read each statement, tell me if you think it is
VERY LIKELY, SOMEWHAT LIKELY, SOMEWHAT UNLIKELY, VERY
UNLIKELY, DEFINITELY NOT POSSIBLE, or if you DON'T KNOW HOW
LIKELY it is that a person will get AIDS or the AIDS virus
that way.

How likely do you think it is that a person will get AIDS
or the AIDS virus infection from

a. Living near a home or hospital for AIDS patients.

☐ Very Likely ☐ Somewhat Likely ☐ Somewhat
Unlikely

☐ Very Unlikely ☐ Definitely Not Possible ☐ Don't
Know

b. Working near someone with the AIDS virus

☐ Very Likely ☐ Somewhat Likely ☐ Somewhat
Unlikely

☐ Very Unlikely ☐ Definitely Not Possible ☐ Don't
Know

c. Eating in a restaurant where the cook has the AIDS

virus.

___Very Likely ___Somewhat Likely ___Somewhat

Unlikely

___Very Unlikely ___Definitely Not Possible ___Don't

Know

d. Kissing-with exchange of saliva-a person with the AIDS

virus.

___Very Likely ___Somewhat Likely ___Somewhat

Unlikely

___Very Unlikely ---Definitely Not Possible ___Don't

Know

e. Shaking hands, touching or kissing on the cheek,
someone who has the AIDS virus.

___Very Likely ___Somewhat Likely ___Somewhat

Unlikely

___Very Unlikely ___Definitely Not Possible ___Don't

Know

f. Sharing plates, forks or glasses with someone who has
the AIDS virus.

___Very Likely ___Somewhat Likely ___Somewhat

Unlikely

___Very Unlikely ___Definitely Not Possible ___Don't
Know

g. Using public toilets.

___Very Likely ___Somewhat Likely ___Somewhat
Unlikely

___Very Unlikely ___Definitely Not Possible ___Don't
Know

h. Sharing needles for drug use with someone who has the
AIDS virus.

___Very Likely ___Somewhat Likely ___Somewhat
Unlikely

___Very Unlikely ___Definitely Not Possible ___Don't
Know

i. Being coughed on or sneezed on by someone who has the
AIDS virus.

___Very Likely ___Somewhat Likely ___Somewhat
Unlikely

___Very Unlikely ___Definitely Not Possible ___Don't
Know

j. Attending school with a child who has the AIDS virus.

___Very Likely ___Somewhat Likely ___Somewhat
Unlikely

☐ Very Unlikely ☐ Definitely Not Possible ☐ Don't

Know

k. Mosquitos or other insects

☐ Very Likely ☐ Somewhat Likely ☐ Somewhat

Unlikely

☐ Very Unlikely ☐ Definitely Not Possible ☐ Don't

Know

21. Have you ever donated blood?

---Yes

☐ No

☐ Don't Know

22. Have you donated blood.....

a. since march, 1985?

☐ Yes

☐ No

☐ Don't Know

b. In the last 12 months?

☐ Yes

☐ No

☐ Don't Know

23. Have you ever had a blood test that can detect the AIDS virus infection?

☐ Yes

☐ No

☐ Don't Know

The next questions are about the blood test for the AIDS virus infection. No questions will ask what the results are of any test you may have had.

24.To the best of your knowledge, are blood donations routinely tested now for the AIDS virus infection?

☐Yes ☐No ☐Don't Know

25a.Have you ever received counseling or had a talk with a health professional about taking the AIDS test?

☐Yes ☐No ☐Don't Know

25b.Was the discussion.....

1.With a doctor? ☐Yes ☐No ☐Don't Know

2.At a family planning clinic? ☐Yes ☐No ☐Don't Know

3.On an AIDS hotline? ☐Yes ☐No ☐Don't Know

4.At a prenatal clinic? ☐Yes ☐No ☐Don't Know

5.At an STD or sexually transmitted disease clinic?

☐Yes ☐No ☐Don't Know

6.At an AIDS/HIV counseling and testing site?

☐Yes ☐No ☐Don't Know

7.With some other health professional?

☐Yes ☐No ☐Don't Know

26.During that discussion, did you received information about how to avoid getting or passing on the AIDS virus?

27.Here are some methods people used to keep from getting the AIDS virus through sexual activity. After I read each

one, tell me whether you think it is VERY EFFECTIVE, SOMEWHAT EFFECTIVE, NOT AT ALL EFFECTIVE, OR IF YOU DON'T KNOW HOW EFFECTIVE it is in preventing getting the AIDS virus through sexual activity.

How effective is.....

a. Using a diaphragm?

☐ Very Effective ☐ Somewhat Effective ☐ Not At All Effective ☐ Don't Know How Effective ☐ Don't Know Method.

b. Using a condom?

☐ Very Effective ☐ Somewhat Effective ☐ Not At All Effective ☐ Don't Know How Effective ☐ Don't Know Method.

c. Using a spermicidal jelly, form, or cream?

☐ Very Effective ☐ Somewhat Effective ☐ Not At All Effective ☐ Don't Know How Effective ☐ Don't Know Method.

d. Having a Vasectomy?

☐ Very Effective ☐ Somewhat Effective ☐ Not At All Effective ☐ Don't Know How Effective ☐ Don't Know Method.

e. Two people who do not have the AIDS virus having sex only with each other.

☐ Very Effective ☐ Somewhat Effective ☐ Not At All Effective ☐ Don't Know How Effective ☐ Don't Know Method.

28. What are your chances of having the AIDS virus; would you say...

☐ High ☐ Medium ☐ Low ☐ or None? ☐ Don't Know
☐ Refused.

29. What are your chances of getting the AIDS virus; would you say...

☐ High ☐ Medium ☐ Low ☐ or None? ☐ Don't Know
☐ Refused.

30. People have different meanings when you say "High", "Medium", or "Low" chance. If "No chance" is zero-out-of-one hundred, What would you say [High/Medium/Low] is? What number of times out of one hundred?

_____ out of 100 _____ Don't Know

31. Do you say your chance of getting AIDS is (High/Medium) because you

a. Have had a blood transfusion?

☐ Yes ☐ No

b. Have had sexual contact with someone who might have the virus? _____

___Yes ___No

c. Some other reason?

(Specify) _____

___Yes ___No

FEMALES (18-45):

32. In the past twelve months, have you received services or care at.....

a. A prenatal clinic? ___Yes ___No ___Don't Know

b. A maternal and infant health clinic? ___Yes ___NO
___Don't Know.

c. A family planning clinic? ___Yes ___No ___Don't
Know.

d. A hospital as an Inpatient? ___Yes ___No ___Don't
Know.

e. A hospital emergency room? ___Yes ___No ___Don't
Know.

f. A tuberculosis clinic? ___Yes ___No ___Don't Know.

g. A drug treatment facility or clinic? ___Yes ___no
___Don't Know.

h. An STD (Sexually transmitted disease) clinic? ___Yes
___No ___Don't Know.

i. An alcohol treatment facility or clinic? ☐ Yes ☐ No
☐ Don't Know.

j. An AIDS counseling or testing clinic? ☐ Yes ☐ NO
☐ Don't Know.

k. A community health clinic? ☐ Yes ☐ No ☐ Don't
Know .

l. A public health clinic? ☐ Yes ☐ NO ☐ Don't Know.

33. In the past twelve months, have you.....

a. Been in the job corps?

☐ Yes ☐ No ☐ Don't Know

b. Had a physical examination to join the military?

☐ Yes ☐ No ☐ Don't Know

c. Been in prison?

☐ Yes ☐ No ☐ Don't Know

34. Have you ever discussed AIDS with a friend or relative?

☐ Yes ☐ No ☐ Don't Know

35. When was the last time you discussed AIDS with a friend
or relative?

☐ Today

☐ Days ago

☐ Weeks ago

☐ Months ago

☐ Years ago

☐ Don't Know

36. Have you ever personally known anyone with AIDS or the AIDS virus?

☐ Yes ☐ No ☐ Don't Know

37. How long has it been since you saw this person?

☐ Within the past two weeks
☐ Two weeks to less than one month
☐ One month to less than three months
☐ Three months to less than six months
☐ Six months or more
☐ Don't Know

38. How well do you know this person? Would you say.....

☐ Very well, it is a close relationship
☐ Fairly well, but it is not a close relationship
☐ Not very well, it is only an acquaintance or casual relationship.

☐ You don't really know them personally, such as a friend or friend of a friend.

☐ Other

(Specify) _____

39. I am going to read a list of statements. After I have read them all, please tell me if any of these statements is

true for you. Do not tell me which statement or statements are true for you, just if any of them are.

- a. You have hemophilia and have received clotting factor concentrate since 1977.
- b. You are a native of Haiti, Central or East Africa who has entered the United States since 1977.
- c. You are a man who has had sex with another man at some time since 1977, even one time.
- d. You have taken illegal drugs by needle or any time since 1977.
- e. Since 1977, you are or have been the sex partner of any person who would answer " yes" to any of these items (I have read) .
- f. You have had sex for money or drugs at any time since 1977.

☐ Yes to at least one statement

☐ No to all statements

40. The U.S. Public Health Service has said that AIDS is one of the major health problems in the country but exactly how many people it affects is not known. The Surgeon General has proposed that a study be conducted and blood samples be taken to help find out how widespread the problem is.

If you were selected in this national sample of people to have their blood tested with assurances of privacy of the test results, would you have the test?

☐ Yes ☐ No ☐ Don't Know
☐ Other
(Specify) _____

41. Why wouldn't you take part in this test? (Mark all that apply)

☐ Don't want to know if I have AIDS.
☐ Don't want any counseling about AIDS.
☐ Fear I'll get AIDS from the test.
☐ Don't like to give blood.
☐ Don't trust government programs.
☐ It is a waste of money.
☐ Don't believe AIDS can really be cured anyway.
☐ Other
(Specify) _____
☐ Don't Know

42a. If it were not possible to provide you with the results of this test, would you still take part in the study?

☐ Yes ☐ No ☐ Don't Know

42b. If the results of this test were not provided to you, then would you take part in the study?

☐ Yes

☐ No

☐ Don't Know

43. When federal Public Health officials give information about AIDS, do you believe what they say or are you doubtful about the information they give?

☐ Believe them

☐ Doubtful

☐ Don't Know

44. When they gave advice about how to help keep from getting AIDS, do you believe their advice or are you doubtful about what they say?

☐ Believe them

☐ Doubtful

☐ Don't Know

THE FOLLOWING QUESTIONS ARE ABOUT DRUG USE IN YOUR COMMUNITY. CHECK ONE(X).

45. During the past three months, how often have you heard of adults in your community using heroin?

☐ Many times

☐ Several times

☐ Few times

☐ Once

☐ Never

46. During the past three months, how often have you heard of teenagers in your community using crack?

- ☐ Many times
☐ Several times
☐ Few times
☐ Once
☐ Never

47. During the past three months, how often have you heard of adults in your community using cocaine?

- ☐ Many times
☐ Several times
☐ Few times
☐ Once
☐ Never

48. During the past three months, have you used any of the drugs listed below? CHECK (X).

- | | | |
|-----------------|------------------------------|-----------------------------|
| 1. Heroin | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Cocaine | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Tranquilizer | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Crack | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Other | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

49. During the past three months, how often did you use: (), (), (). [Write in the appropriate drug].

1. ___ Several times a day
2. ___ Once a day
3. ___ Several times a week
4. ___ Once a week
5. ___ Several times a month
6. ___ Once a month
7. ___ Less than once a month
8. ___ Never
9. ___ Other

(Specify) _____

50. In your community, is crack considered to be:

CHECK ONE (X)

1. ___ Very expensive
2. ___ Moderately expensive
3. ___ Very inexpensive

51. I am comfortable with discussing AIDS and sex with other parents.

1. Strongly Agree
2. Moderately Agree
3. Slightly Agree
4. Slightly Disagree

5.Moderately Disagree

6.Strongly Disagree

52.I am comfortable with discussing AIDS and sex with my children.

1.Strongly Agree

2.Moderately Agree

3.Slightly Agree

4.Slightly Disagree

5.Moderately Disagree

6.Strongly Disagree

53.I am comfortable with discussing AIDS and drugs with other parents.

1.Strongly Agree

2.Moderately Agree

3.Slightly Agree

4.Slightly Disagree

5.Moderately Disagree

6.Strongly Disagree

54.I am comfortable with discussing AIDS and drugs with my children.

1.Strongly Agree

2.Moderately Agree

3.Slightly Agree

- 4.Slightly Disagree
- 5.Moderately Disagree
- 6.Strongly Disagree

55.When I discuss AIDS with my children they will change their behavior.

- 1.Strongly Agree
- 2.Moderately Agree
- 3.Slightly Agree
- 4.Slightly Disagree
- 5.Moderately Disagree
- 6.Strongly Disagree

APPENDIX C

Name-----

Address-----

Subject I D Number-----

Date of Interview-----

Test Time:-----

1. Pretest
2. Posttest
3. Follow-Up

The Problem-Solving InventoryInstructions:

READ EACH STATEMENT AND INDICATE THE EXTENT TO WHICH YOU
AGREE OR DISAGREE WITH THE STATEMENT, USING THE FOLLOWING
ALTERNATIVES:

- 1=STRONGLY AGREE
- 2=MODERATELY AGREE
- 3=SLIGHTLY AGREE
- 4=MODERATELY DISAGREE
- 5=STRONGLY DISAGREE

1. ____When a solution to a problem was unsuccessful, I did not examine why it didn't work.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

2. ____When I am confronted with a complex problem, I do not bother to develop a strategy to collect information so I can define exactly what the problem is.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

3. ____When my first efforts to solve a problem fail, I become uneasy about my ability to handle the situation.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

4. ____After I have solved a problem, I do not analyze what went right or what went wrong.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

5. ____I am usually able to think creative and effective alternatives to solve a problem.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

6. ___After I have tried to solve a problem with a certain course of action, I take time to compare the actual outcome to what I think should have happened.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

7. ___When I have a problem, I think up as many possible ways to handle it as I can until I can come up with any more ideas.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

8. ___When I am confronted with a problem, I consistently examine my feelings to find out what is going on in a problem situation.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

9. ___When I am confused with a problem, I do not try to define unclear ideas or feelings into concrete or specific terms.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

10. ___I have the ability to solve most problems even though initially no solution is immediately apparent.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

11.____Many problems I face are too complex for me to solve.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

12.____I make decisions and am happy with them later.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

13.____When confronted with a problem, I tend to do the first thing that I can think to solve it.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

14.____Sometimes I do not stop and take time to deal with my problem, but just kind of muddle ahead.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

15.____When deciding on an idea or possible solutions to a problem, I do not take time to consider the chances of each alternative being successful.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |

3.Slightly Agree

6.Strongly Disagree

16.____When confronted with a problem, I stop and think about
it before deciding the next step.

1.Strongly Agree

4.Slightly Disagree

2.Moderately Agree

5.Moderately Disagree

3.Slightly Agree

6.Strongly Disagree

17.____I generally go with the first good idea that comes to
mind.

1.Strongly Agree

4.Slightly Disagree

2.Moderately Agree

5.Moderately Disagree

3.Slightly Agree

6.Strongly Disagree

18.____When making a decision, I weigh the consequences of
each alternative and compare them against each other.

1.Strongly Agree

4.Slightly Disagree

2.Moderately Agree

5.Moderately Disagree

3.Slightly Agree

6.Strongly Disagree

19.____When I make plans to solve a problem, I am almost
certain that I can make them work.

1.Strongly Agree

4.Slightly Disagree

2.Moderately Agree

5.Moderately Disagree

3.Slightly Agree

6.Strongly Disagree

20.____I try to predict the overall results of carrying out a
particular course of action.

1.Strongly Agree

4.Slightly Disagree

2.Moderately Agree

5.Moderately Disagree

3.Slightly Agree

6.Strongly Disagree

21. ___When I try to think of possible solutions to a problem, I do not come up with very many alternatives.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

22. ___In trying to solve a problem, one strategy I often use is to think of past problems that have been similar.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

23. ___Given enough time and effort, I believe I can solve most problems.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

24. ___When faced with a new situation, I have confidence that can handle problems that may arise.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

25. ___Even though I work on a problem, sometimes I feel like I am groping or wandering, and am not getting down to the real issue.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

26. ___I make snap judgments and later regret them.

1.Strongly Agree

4.Slightly Disagree

2.Moderately Agree

5.Moderately Disagree

3.Slightly Agree

6.Strongly Disagree

27. ___I trust my ability to solve new and difficult problems.

1.Strongly Agree

4.Slightly Disagree

2.Moderately Agree

5.Moderately Disagree

3.Slightly Agree

6.Strongly Disagree

28. ___I have a systematic method for comparing alternatives and making decisions.

1.Strongly Agree

4.Slightly Disagree

2.Moderately Agree

5.Moderately Disagree

3.Slightly Agree

6.Strongly Disagree

29. ___When I try to think of ways of handling a problem, I do not try to combine different ideas together.

1.Strongly Agree

4.Slightly Disagree

2.Moderately Agree

5.Moderately Disagree

3.Slightly Agree

6.Strongly Disagree

30. ___When confronted with a problem, I don't usually examine what sort of external things in my environment may be contributing to my problem.

1.Strongly Agree

4.Slightly Disagree

2.Moderately Agree

5.Moderately Disagree

3.Slightly Agree

6.Strongly Disagree

31. ___ When I am confronted with a problem, one of the first things that I do is survey the situation and consider all the relevant pieces of information.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

32. ___ Sometimes I get so charged up emotionally that I am unable to consider many ways of dealing with my problem.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

33. ___ After making a decision, the outcomes I expected usually matches the actual outcome.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

34. ___ When confronted with a problem, I am unsure of whether I can handle the situation.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |
| 3.Slightly Agree | 6.Strongly Disagree |

35. ___ When I become aware of a problem, one of the first things I do is try to find out exactly what the problem is.

- | | |
|--------------------|-----------------------|
| 1.Strongly Agree | 4.Slightly Disagree |
| 2.Moderately Agree | 5.Moderately Disagree |

3.Slightly Agree

6.Strongly Disagree

APPENDIX D

Name _____

Address _____

Subject I D Number _____

Date of Interview _____

Test Time: _____

1. Pretest

2. Posttest

3. Follow-Up

SIMPLE RATHUS ASSERTIVENESS INVENTORYINSTRUCTIONS:

READ EACH SENTENCE CAREFULLY. WRITE DOWN ON EACH LINE
WHATEVER NUMBER IS CORRECT FOR YOU:

6=VERY MUCH LIKE ME

5=RATHER LIKE ME

4=SOMEWHAT LIKE ME

3=SOMEWHAT UNLIKE ME

2=RATHER UNLIKE ME

1=VERY UNLIKE ME

1. ___ Most people stand up for themselves more than I do.

- | | |
|----------------------|-----------------------|
| 6. Very much like me | 3. Somewhat unlike me |
| 5. Rather like me | 2. Rather unlike me |
| 4. Somewhat like me | 1. Very unlike me |

2. ___ At times I have not made or gone on dates because of my shyness.

- | | |
|----------------------|-----------------------|
| 6. Very much like me | 3. Somewhat unlike me |
| 5. Rather like me | 2. Rather unlike me |
| 4. Somewhat like me | 1. Very unlike me |

3. ___ When I am eating out and the food I am served is not cooked the way I like it, I complain to the person serving it.

- | | |
|----------------------|-----------------------|
| 6. Very much like me | 3. Somewhat unlike me |
| 5. Rather like me | 2. Rather unlike me |
| 4. Somewhat like me | 1. Very unlike me |

4. ___ I am careful not to hurt other people's feelings, even when I feel hurt.

- | | |
|----------------------|-----------------------|
| 6. Very much like me | 3. Somewhat unlike me |
| 5. Rather like me | 2. Rather unlike me |
| 4. Somewhat like me | 1. Very unlike me |

5. ___ If a person serving in a store has gone to a lot of trouble to show me something which I do not really like, I have a hard time saying no.

- | | |
|----------------------|-----------------------|
| 6. Very much like me | 3. Somewhat unlike me |
| 5. Rather like me | 2. Rather unlike me |

4.Somewhat like me

1.Very unlike me

6. ____When I am asked to do something, I always want to know why.

6.Very much like me

3.Somewhat unlike me

5.Rather like me

2.Rather unlike me

4.Somewhat like me

1.Very unlike me

7. ____There are times when I look for a good strong argument.

6.Very much like me

3.Somewhat unlike me

5.Rather like me

2.Rather unlike me

4.Somewhat like me

1.Very unlike me

8. ____I try as hard to get along in life as most people like me do.

6.Very much like me

3.Somewhat unlike me

5.Rather like me

2.Rather unlike me

4.Somewhat like me

1.Very unlike me

9. ____To be honest, people often get the better of me.

6.Very much like me

3.Somewhat unlike me

5.Rather like me

2.Rather unlike me

4.Somewhat like me

1.Very unlike me

10. ____I enjoy meeting and talking with people for the first time.

6.Very much like me

3.Somewhat unlike me

5.Rather like me

2.Rather unlike me

4.Somewhat like me

1.Very unlike me

11.____I often don't know what to say to good looking people
of the opposite sex.

6.Very much like me

3.Somewhat unlike me

5.Rather like me

2.Rather unlike me

4.Somewhat like me

1.Very unlike me

12.____I do not like making phone calls to businesses or
companies.

6.Very much like me

3.Somewhat unlike me

5.Rather like me

2.Rather unlike me

4.Somewhat like me

1.Very unlike me

13.____I would rather apply for jobs by writing letters than
by going to talk to the people.

6.Very much like me

3.Somewhat unlike me

5.Rather like me

2.Rather unlike me

4.Somewhat like me

1.Very unlike me

14.____I feel silly if I return things I don't like to the
store that I bought them from.

6.Very much like me

3.Somewhat unlike me

5.Rather like me

2.Rather unlike me

4.Somewhat like me

1.Very unlike me

15.____If a close relative that I like was upsetting me, I
would hide my feelings rather than say that I was upset.

6.Very much like me

3.Somewhat unlike me

5.Rather like me

2.Rather unlike me

4.Somewhat like me

1.Very unlike me

16. ___ I have sometimes no asked questions for fear of sounding silly.

- | | |
|----------------------|-----------------------|
| 6. Very much like me | 3. Somewhat unlike me |
| 5. Rather like me | 2. Rather unlike me |
| 4. Somewhat like me | 1. Very unlike me |

17. ___ During an argument I am sometimes afraid that I will get so upset that I will shake all over.

- | | |
|----------------------|-----------------------|
| 6. Very much like me | 3. Somewhat unlike me |
| 5. Rather like me | 2. Rather unlike me |
| 4. Somewhat like me | 1. Very unlike me |

18. ___ If a famous person were talking in a crowd and I thought he or she were wrong, I would get up and say what I thought.

- | | |
|----------------------|-----------------------|
| 6. Very much like me | 3. Somewhat unlike me |
| 5. Rather like me | 2. Rather unlike me |
| 4. Somewhat like me | 1. Very unlike me |

19. ___ I don't argue over prices with people selling things.

- | | |
|----------------------|-----------------------|
| 6. Very much like me | 3. Somewhat unlike me |
| 5. Rather like me | 2. Rather unlike me |
| 4. Somewhat like me | 1. Very unlike me |

20. ___ When I do something important or good, I try to let others know about it.

- | | |
|----------------------|-----------------------|
| 6. Very much like me | 3. Somewhat unlike me |
| 5. Rather like me | 2. Rather unlike me |
| 4. Somewhat like me | 1. Very unlike me |

21. ___ I am open and honest about my feelings.

6. Very much like me

3. Somewhat unlike me

5. Rather like me

2. Rather unlike me

4. Somewhat like me

1. Very unlike me

22. ___ If someone has been telling false and bad stories about me, I see him (her) as soon as possible to "have a talk" about it.

6. Very much like me

3. Somewhat unlike me

5. Rather like me

2. Rather unlike me

4. Somewhat like me

1. Very unlike me

23. ___ I often have a hard time saying "no".

6. Very much like me

3. Somewhat unlike me

5. Rather like me

2. Rather unlike me

4. Somewhat like me

1. Very unlike me

24. ___ I tend not to show my feelings rather than upsetting others.

6. Very much like me

3. Somewhat unlike me

5. Rather like me

2. Rather unlike me

4. Somewhat like me

1. Very unlike me

25. ___ When someone says that I have done very well, I sometimes just don't know what to say.

6. Very much like me

3. Somewhat unlike me

5. Rather like me

2. Rather unlike me

4. Somewhat like me

1. Very unlike me

26. ___ I complain about poor services when I am eating out or in other places.

6. Very much like me

3. Somewhat unlike me

5. Rather like me

2. Rather unlike me

4. Somewhat like me

1. Very unlike me

27. ___ If a couple near me in the theatre were talking rather loudly, I would ask them to be quiet or to go somewhere else and talk.

6. Very much like me

3. Somewhat unlike me

5. Rather like me

2. Rather unlike me

4. Somewhat like me

1. Very unlike me

28. ___ Anyone trying to push ahead of me in a line is in for a good battle.

6. Very much like me

3. Somewhat unlike me

5. Rather like me

2. Rather unlike me

4. Somewhat like me

1. Very unlike me

29. ___ I am quick to say what I think.

6. Very much like me

3. Somewhat unlike me

5. Rather like me

2. Rather unlike me

4. Somewhat like me

1. Very unlike me

30. ___ There are times when I just can't say anything.

6. Very much like me

3. Somewhat unlike me

5. Rather like me

2. Rather unlike me

4. Somewhat like me

1. Very unlike me

APPENDIX E

Name _____

Address _____

Subject I D Number _____

Date of Interview _____

Test Time: _____

1. Pretest

2. Posttest

3. Follow-Up

FREQUENCY OF SELF-REINFORCEMENT QUESTIONNAIREINSTRUCTIONS:

BELOW ARE A NUMBER OF STATEMENTS ABOUT BELIEFS OR ATTITUDES PEOPLE HAVE. INDICATE HOW DESCRIPTIVE THE STATEMENTS ARE FOR YOURSELF BY RATING EACH ITEM, AS INDICATED BELOW. THERE ARE NO RIGHT OR WRONG ANSWERS. YOUR ANSWERS ARE CONFIDENTIAL.

RATE EACH ITEM FOR HOW MUCH OF THE TIME IT IS DESCRIPTIVE FOR YOU. IN THE BLANK BEFORE EACH ITEM, RATE:

0=NEVER DESCRIPTIVE OF ME

1=A LITTLE OF THE TIME DESCRIPTIVE OF ME

2=SOME OF THE TIME DESCRIPTIVE OF ME

3=MOST OF THE TIME DESCRIPTIVE OF ME

1. ___ When I fail at something, I am still able to feel good about myself.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

2. ___ I can stick to a boring task that I need to finish without someone pushing me.

0.Never descriptive of me

1.A little of the time descriptive of me.

2.Some of the time descriptive of me

3.Most of the time descriptive of me

3. ___ I have negative thoughts about myself.

0.Never descriptive of me

1.A of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

4. ___ When I do something right, I take time to enjoy the feeling.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

5. ___I have such high standards for what I expect of myself that I have a hard time meeting my standards.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

6. ___I seem to blame myself and be very critical to myself when things go wrong.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

7. ___I can have a good time doing some things alone.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

8. ___I get upset with myself when I make mistakes.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

9. ___My feelings of self-confidence go up and down.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3. Most of the time descriptive of me

10. ___ When I succeed at small things, it helps me to go on.

0. Never descriptive of me

1. A little of the time descriptive of me

2. Some of the time descriptive of me

3. Most of the time descriptive of me

11. ___ If I do not do something absolutely perfectly, I don't feel satisfied.

0. Never descriptive of me

1. A little of the time descriptive of me

2. Some of the time descriptive of me

3. Most of the time descriptive of me

12. ___ I get myself through hard things mostly by thinking I'll enjoy myself afterwards.

0. Never descriptive of me

1. A little of the time descriptive of me

2. Some of the time descriptive of me

3. Most of the time descriptive of me

13. ___ When I make mistakes, I take time to criticize myself.

0. Never descriptive of me

1. A little of the time descriptive of me

2. Some of the time descriptive of me

3. Most of the time descriptive of me

14. ___ I encourage myself to improve at something by feeling good about myself.

0. Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

15.____I put myself down so that I will do things better in the future.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

16.____I think talking about what you've done right is bragging.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

17.____I find that I feel better when I silently praise myself.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

18.____I can keep working at something hard to do when I stop to think of what I've already done.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3. Most of the time descriptive of me

19. ___ The way I keep up my self-confidence is by remembering any successes I've had.

0. Never descriptive of me

1. A little of the time descriptive of me

2. Some of the time descriptive of me

3. Most of the time descriptive of me

20. ___ The way I achieve my goals is by rewarding myself every step along the way.

0. Never descriptive of me

1. A little of the time descriptive of me

2. Some of the time descriptive of me

3. Most of the time descriptive of me

21. ___ Praising yourself is being selfish.

0. Never descriptive of me

1. A little of the time descriptive of me

2. Some of the time descriptive of me

3. Most of the time descriptive of me

22. When someone criticizes me, I lose my self-confidence.

0. Never descriptive of me

1. A little of the time descriptive of me

2. Some of the time descriptive of me

3. Most of the time descriptive of me

23. ___ I criticize myself more often than others criticize me.

0. Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

24. ___ I feel I have a lot of good qualities.

0.Never descriptive of me

1.A little of the time descriptive for me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

25. ___ I silently praise myself even when other people do not
praise me.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

26. ___ Any activity can provide some pleasure no matter how
it comes out.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

27. ___ If I don't do the best possible job, I don't feel good
about myself.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

28. ___ I should be upset If I make a mistake.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

29. ___ My happiness depends more on myself than it depends on other people.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me

30. ___ People who talk about their own better points are just bragging.

0.Never descriptive of me

1.A little of the time descriptive of me

2.Some of the time descriptive of me

3.Most of the time descriptive of me